

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO	DATE
Myers	4-1-08

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOC NUMBER	000504	<input type="checkbox"/> Prepare reply for the Director's signature	DATE DUE _____
2. DATE SIGNED BY DIRECTOR	<i>N/A per Myers & Givens on 4/3/08, see attached note</i>	<input type="checkbox"/> Prepare reply for appropriate signature	DATE DUE _____
		<input type="checkbox"/> FOIA	DATE DUE _____
		<input checked="" type="checkbox"/> Necessary Action	

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			



STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

ESRD - ENROLLMENT MEDICAID RECIPIENT

PART I - PATIENT INFORMATION

Name	Trenis L. Williams	Date of Birth	01-10-79	Social Security No:	252-33-3657
Address	160 Forest Drive	Medicaid ID No:	1780811762	Medicare Eligible	yes
STREET OR R.F.D.		Medicare Application Submitted.			
Jackson SC 29831		<input checked="" type="radio"/> Yes	Date		
CITY STATE ZIP CODE		Effective Date	—	Medicare Denied:	<input checked="" type="checkbox"/> No
Country	Aiken	Medicaid No.	Pending		

REASON FOR DENIAL Medicine is Pending

PART II - TREATMENT INFORMATION - DIALYSIS

Date of First Treatment	12-13-07	Treatment Candidate?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------	----------	----------------------	---

Name of Facility Transferred From

—

Mode of Treatment

☒ HEMODIALYSIS

PERITONEAL DIALYSIS

SEE # 0141YSIS

Hemodialysis:

TYPE

SUPPLIER

PART III - MEDICAL TRANSPORTATION

Referral Made by DSS

No

Priority of Transportation

ESRD PROVIDER INFORMATION

HHSPC USE ONLY

NCA-Augusta Dialysis

000954049 B

Dr. Brezina / 622412626F

Mhairyn Hilton (706) 774-0130

Social Worker

3-6-08

From: Nancy Rabert
To: Margarete Keller
Date: 4/3/2008 9:03 AM
Subject: Re: Can Log 000504 -

CC: Brenda James; Jan Polatty
OK

>>> Margarete Keller 4/3/2008 9:01 AM >>>
You need to respond - Felicity requests an answer to the physician.

Marga :-)

>>> Nancy Rabert 4/3/2008 8:48 AM >>>
Can it be changed to Necessary Action. It is a normal form/application with normal procedures -just like what we send on to Physicians. This one goes to Hospitals. Nothing unusual about it - just that it got opened on 11th and logged. Thoughts?

Thanks
Nancy

*done 4/3/08
Felicity = BZ
apoke about
2:50 PM
4/3/08*

*to
vnd
hof
B3*

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Myers / Giese</i>	DATE <i>4-1-08</i>
----------------------------	-----------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000504</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Closed - See attached note,</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-10-08</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

RECEIVED
 Dept. of Health
 & Human Services
APR 05 2008
 Bureau of
 Health Services



STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION
ESRD - ENROLLMENT MEDICAID RECIPIENT

PART I - PATIENT INFORMATION

Name:	<u>Trenis L. Williams</u>		Date of Birth:	<u>01-10-79</u>	Social Security No:	<u>252-33-3657</u>
Address:	<u>160 Forest Drive</u>		Medicaid ID No:	<u>1780811762</u>	Medicare Eligible	<u>yes</u>
STREET OR RFD			Medicare Application Submitted.			
<u>Jackson</u>	<u>SC</u>	<u>29831</u>	<input checked="" type="radio"/> Yes	Date		
CITY	STATE	ZIP CODE				
County:	<u>Aiken</u>	Medicare No:	<u>Pending</u>	Effective Date:	<u>—</u>	Medicare Denied: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
REASON FOR DENIAL: <u>Medicare is Pending</u>						

PART II - TREATMENT INFORMATION - DIALYSIS

Date of First Treatment:	Transplant Candidate:
<u>12-13-07</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Name of Facility Transferred From: —

Mode of Treatment:

- ☒ HEMODIALYSIS
☐ PERITONEAL DIALYSIS
☐ SELF DIALYSIS

Home Dialysis:	
TYPE:	_____
SUPPLIER:	_____

PART III - MEDICAL TRANSPORTATION

Reimbursed by DSS:	Provider of Transportation:
<input type="checkbox"/> Yes <input type="checkbox"/> No	

ESRD PROVIDER INFORMATION

Clinic Name:	<u>NCA - Augusta Dialysis</u>
Provider Number:	<u>000954049 B</u>
Physician's Name:	<u>Dr. Brezina / 622472626F</u>
Form Completed By:	<u>Marissa Hinton (706) 774-0130</u>
NAME	TELEPHONE NO.
<u>Social Worker</u>	<u>3-6-08</u>
TITLE	DATE

HHSFC USE ONLY

ESRD Enrolled:	
Code:	
Effective Date:	
Approved By:	
Date Approved:	
Comments:	

MAIL TO:

ESRD SERVICES - DIVISION OF PRIMARY CARE
S.C. HEALTH AND HUMAN SERVICES FINANCE
COMMISSION

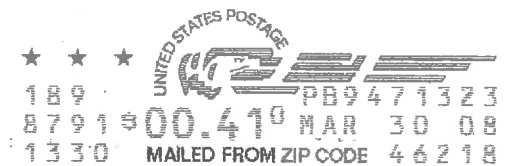
P.O. BOX 8206

COLUMBIA, S.C. 29202 - 8206

HHSFC 218 (Apr 86)

Replaces DSS Form 17112 (Aug 83) which is obsolete.

ARA
AUGUSTA CLINIC LLC
Nephrology Centers of America - Augusta
4000 Telfair Street
Augusta, GA 30901-2208



*ESRD Services - Division of Primary Care
SC Health and Human Services Finance
Commission*

P.O. Box 8206

Columbia, SC 29202-8206