

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

Val

TO <i>Myers / Gail Hamilton</i>	DATE <i>9-23-10</i>
------------------------------------	----------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>000138</i>		<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR <i>Cleand 10/18/10</i>		<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>10-4-10</i>	
<i>Letter attached to be attached to this. J. Profs. name</i>		<input type="checkbox"/> FOIA DATE DUE _____	
		<input type="checkbox"/> Necessary Action	

APPROVALS <small>(Only when prepared for director's signature)</small>	APPROVE	* DISAPPROVE <small>(Note reason for disapproval and return to preparer.)</small>	COMMENT
1. <i>[Signature]</i>	<i>10/04/10</i>		
2. <i>BS Green</i>	<i>10/19 OK</i>	<i>lets</i>	<i>comment and comments</i>
3. <i>Val Williams</i>	<i>10-18-10</i>		
4.	<i>10-13-10</i>		

SEP 30 2010
DIVISION OF CARE MANAGEMENT

RECEIVED
Bureau of Health & Human Services
SEP 28 2010
BUREAU OF CARE MGMT.
Bureau of Health Services

08-09-10

From: Sally Ann Ryan
3628 Maybank Highway
Apartment G9
Johns Island, SC 29455

RECEIVED

SEP 23 2010

TO: Director of ^{Department of Health & Human Services} ~~OFFICE OF THE~~ DIRECTOR ^{SC} Carolina

I am getting calls from a collection agency about these bills. The bills are for, while visiting Arizona I ran out of some important medicines for on for psoriatic arthritis in my spine and sit joints, I called every doctor clinic, and walk-in place, and they could not take me. That was on the advice of my doctor back home in S. Carolina at MUSC Rutledge Tower, 8th Floor, Dr. Sandhu, or the attending physician of the day there. So, I ended up in the E.R. at Tucson, Arizona UMC Hospital. First they took me in a room to find out about payment. I showed them my insurance cards, they copied them and made some phone calls. Then they said OK, go ahead and be seen here, the bill will be all taken care of. I have a very

Severe, special disease, and really can not travel any more after this happened. I called my doctors office several times, begging them to write a letter to Medicaid. I wrote them a letter, and they gave me my chart back when I moved to Johns Island, closer to doctors. I found my original better, and the enclosed copies of my Tucson bills. They never did anything about it. Dr. Sandhu did this on purpose because I complained to the hospital about her hitting me, and nothing was done about that either. Thank You Sally Ryan (843) 789-3048

Change of Name, Address or Insurance Coverage

1. Patient Information Last Name <u>Ryan</u> First Name <u>Sally</u> M Street Address <u>308 Maybank Hwy, Apt. G 9 (843) 789 3048</u> City <u>Johns Island, SC</u> State <u>29435</u> Telephone Number <u> </u>			
2. Medicare ID # <u> </u> <input type="checkbox"/> Primary Ins. <input type="checkbox"/> Secondary Ins. Part A - Hospital Ins. <input type="checkbox"/> Effective Date <u> </u> Part B - Physician Ins. <input type="checkbox"/> Effective Date <u> </u>		4. Other Coverage - Primary <input type="checkbox"/> Managed Medicare <input checked="" type="checkbox"/> Managed Medicaid Effective Date <u>3 Oct, '07</u> Insurance Co. Name <u>First Choice by Select Health of SC</u> Insurance Co. Street Address <u>P.O. Box 7120</u> Insurance Co. City/State/Zip <u>London KY 40792</u> Subscriber's Name <u>Sally A. Ryan</u> ID # <u>40593877</u> Group # <u> </u>	
3. Medicaid Name on Card <u>Sally A. Ryan</u> Effective Date <u>Oct '07</u> a. State ID # <u>6780804243</u> Program ID # <u> </u> b. City of <u>Johns Island</u> ID # <u> </u>		5. Other Coverage - Secondary <input type="checkbox"/> Managed Medicare <input type="checkbox"/> Managed Medicaid Effective Date <u> </u> Insurance Co. Name <u> </u> Insurance Co. Street Address <u> </u> Insurance Co. City/State/Zip <u> </u> Subscriber's Name <u> </u> ID # <u> </u> Group # <u> </u>	

I'm not sure which one is Primary and Secondary. *** If possible, please enclose a front & back copy of your Insurance ID Card with this change ***

STATEMENT OF MEDICAL SERVICES

To the Hospital - you can call Ins. Co. @ (803) 898-2600 OR 1-888-809-3040 for verification.

I sat 5 hours in your E.R. waiting to be seen first in an office where you verify payment. ~~they~~ You said it was all covered. I would never have bothered you but tried to get an appointment, but NO doctors in the area were taking any new patients, and even walk-in places were too full, and clinics. So this was about to be an emergency and I was glad to see you were open. I needed the fentanyl patch, and Lyrica for to treat my psoriatic arthritis in spine and S.I. joints, and lots of nerve damage. I will have my primary-care Dr. Sandhu at MUSE in Charleston, S.C. call you. Thank You.

They would NOT ever call, Sally Ryan. ~~So~~ There are 2 separate bills, one for the hospital's emergency room, the other is for the physician.

to Dr. Sally
05/11/99
I also need someone to
contact ~~1-800-607-5666~~ ¹⁻⁸⁰⁰⁻³³³⁻³³³³
about a bill I had from when
I was in Arizona in Tucson
on 02-13-08. I had to go to
the Emergency Room at UMC Hospital
Because I needed the Duragesic Patch 25
and Lyrica 200 mg. There were NO doctors
that could take anyone, even drop-ins.
So therefore, I need you
to tell them it was an <sup>All the other doctors
clinics, and
walk-ins
were full.</sup> emergency. Thank You Sally
To get medicine at the E.R. 07-06-1959



UNIVERSITY PHYSICIANS HEALTHCARE

INQUIRIES Call 520-874-7200 or Toll Free at 866-467-2581

☒ YOUR CURRENT INSURANCE IS LISTED BELOW, CHECK THIS BOX IF YOUR ADDRESS OR INSURANCE HAS CHANGED AND MAKE CHANGES ON REVERSE SIDE.
1. UNINSURED SELF PAY
2. NONE

PATIENT: SALLY RYAN

MAKE CHECK PAYABLE TO: UNIVERSITY PHYSICIANS CHECK # _____

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD NUMBER: _____

SIGNATURE: _____ EXP DATE: _____

ACCT # STATEMENT DATE AMOUNT DUE NOW AMOUNT ENCLOSED
15317233 05/05/08 \$242.00 \$

|||||
SALLY RYAN

1020 CHARITY CHURCH RD 2328 MB 0.360 AMECH
HUGER, SC 29450-9517

MAIL PAYMENT TO:

UNIVERSITY EMERGENCY PHYSICIANS
PO BOX 29681
PHOENIX, AZ 85038-9681

|||||

PLEASE DETACH THIS TOP PORTION AND REMIT WITH YOUR PAYMENT

STATEMENT OF MEDICAL SERVICES

(AS OF MAY 5, 2008)

ACCT NUMBER: 15317233
PATIENT NAME: SALLY RYAN

PAGE 1

THE FOLLOWING INVOICES DESCRIBE OUTSTANDING CHARGES FOR SERVICES RENDERED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS AT UNIVERSITY PHYSICIANS HEALTHCARE. THE LEFT SIDE DESCRIBES THE SERVICES PROVIDED AND THE CHARGES FOR EACH SERVICE. THE RIGHT SIDE DESCRIBES PAYMENTS, ADJUSTMENTS, INSURANCE FILINGS, AND THE AMOUNT YOU OWE.

INVOICE NUMBER: 16326297
CHARGES

PROVIDER: BEN A LEESON MD
EMERGENCY MEDICINE

02/13/08 99203/GC-OFFICE VISIT
DIAGNOSIS CODE: 338.29, 785.0, 787.91

TOTAL: \$242.00

PAYMENT ACTIVITY
02/13/08 TOTAL CHARGES \$242.00
AMOUNT DUE NOW \$242.00
NOTE: NO INSURANCE CLAIM WAS FILED FOR THIS SERVICE.
IF YOU HAVE INSURANCE THAT COVERS THIS SERVICE, PLEASE
CALL OUR OFFICE AT 520-874-7200 OR 866-467-2581.

OUR CORPORATE OFFICE IS NOW LOCATED AT 2701 E ELVIRA RD. TUCSON, AZ 85706. IF YOU HAVE ANY QUESTIONS PLEASE CALL 520-874-7200 OR TOLL FREE AT 866-467-2581. OUR OFFICE HOURS ARE 9:00AM TO 4:00PM MONDAY THROUGH FRIDAY.

THE BALANCE OF YOUR ACCOUNT IS PAST DUE AND PAYMENT IS DUE NOW. IF PAYMENT IN FULL IS NOT RECEIVED WITHIN 10 DAYS, YOUR ACCOUNT MAY BE REFERRED TO A COLLECTION AGENCY. FAILURE TO MAKE IMMEDIATE PAYMENT MAY IMPACT YOUR CREDIT RECORD.

Bill for Doctors at ER,
at University Medical Center
1501 N. Campbell Ave.
Tucson, Az 85724

AMOUNT DUE NOW: \$242.00



PO Box 12949
Tucson, AZ 85732
Address Service Requested

June 18, 2008

PRIORITY NOTICE



Surety Acceptance Corporation
(520) 790-7181

ACCOUNT IDENTIFICATION

Creditor: University Physicians
and 15317233 16326297
Account Number
Total Due : \$250.36

242.00 he said
Spoke 2 Bruce Myers
from Sun

Sally Ryan
1020 Charity Church Rd
Huger, SC 29450-9517

CREDIT BUREAU NOTIFICATION!

If this obligation is paid in full in a timely manner, it may not be recorded as an unpaid collection item on your credit bureau file.

YOU ARE HEREBY ADVISED

Your creditor has assigned this debt to Surety Acceptance Corporation for collection. To prevent further action, bring or mail payment in full to above address!

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will: obtain verification of the debt or obtain a copy of a judgement and mail you a copy of such judgement or verification. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

This letter is from a debt collector and is an attempt to collect a debt. Any information obtained will be used for that purpose.

-----Detach and Return with Payment -----
Enter the requested information in the spaces provided below:

From: Sally Ryan

Employer: _____

Change of Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Telephone: _____

Make your check or money order payable to:

Surety Acceptance Corporation
6440 E. Broadway, PO Box 12949
Tucson, AZ 85732

IF PAYING BY CREDIT CARD FILL OUT BELOW				
CARD NUMBER		AMOUNT		
SIGNATURE		EXP. DATE		
ACCOUNT #	CREDITOR	TOTAL AMOUNT DUE	AMOUNT PAID	
3161245	University Physicians 15317233 16326297	\$250.36		



University Medical Center
1501 N. Campbell Ave.
Tucson, AZ 85724



HOSPITAL MONTHLY STATEMENT

Statement Date:

04/28/08

RYAN, SALLY

RETURN SERVICE REQUESTED
520-622-1974

0101

*Statement date
04-28-08*

RYAN, SALLY
1020 CHARITY CHURCH RD
HUGER, SC 29450-9517

Medical Record Number: 15317233
Payment Due Date: 05/23/08
Date(s) of Service: 02/13/08
Primary Insurance: Policy #: 073466781
PENDING AHCCCS
Secondary Insurance: Policy #:
UNINSURED SELF PAY

Page 1 of 2

University Medical Center appreciates your business!

Account Summary (please refer to detail on back)

Total hospital charges	\$ 250.00
Adjustments to date	\$ -191.73
Amount pending from insurance	\$ 0.00
Already paid by insurance	\$ 0.00
Already paid by patient	\$ 0.00
Amount you owe now	\$ 58.27

Please review the above
information for accuracy.

If your information needs to be
changed, you have a billing
question, or you would like to
request an itemized bill, please
contact our Customer Service
Team at 520-622-1974,
1-800-874-4708, or
customerservice@umcaz.edu

Our Business Office hours are
Monday - Friday 8:00 a.m. to
5:00 p.m.

Message... Pay your bill online anytime at www.umcaz.com then click on For Patients.

The purpose of this statement is to notify you of the status of your open hospital accounts. We would appreciate payment in full of the \$58.27. If you are unable to pay this amount in full and would like to set up a budget payment plan, please contact our Customer Service Team at the numbers listed below.

Detach and return with payment. Please make checks payable to University Medical Center and write your account number(s) on the check.

Statement Date:

04/28/08

RYAN, SALLY

Please indicate below which account(s) you are paying.

☐ 3209283 58.27

33815

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER

CARDHOLDER SIGNATURE

3-DIGIT SECURITY CODE

DUE DATE

05/23/08

AMOUNT YOU OWE

\$ 58.27

MED RECORD NUMBER

15317233

Phone: Customer Service Team

Open 8:00 AM - 5:00 PM Monday - Friday
520-622-1974 or 1-800-874-4708

AMOUNT AUTHORIZED / ENCLOSED \$

☐ Please check box if address above is incorrect or insurance information has changed, and indicate change(s) on reverse side.

UNIVERSITY MEDICAL CENTER
P.O. BOX 840334
DALLAS, TX 75284-0334

810768-NC1 - 033446768

PO BOX 19785
IRVINE CA 92623-9785

HRS-I-BALAFINS

HEALTHCARE RECOVERY SOLUTIONS

1515 190th Street, Suite 350
Gardena, CA 90248-4910

Toll Free (800) 337-4359

Fax: (888) 663-6582

04-20-09

Office Hours - 8:30a.m. -- 4:00 p.m. PST
Telephone Hours - Pacific Standard Time
Monday - Friday 8:00 a.m. - 4:30 p.m.

~~SALLY RYAN~~ 810768-NC1
4404 1/2 STREET AVE
NORTH CHARLESTON, SC 29405-5240



ACCOUNT IDENTIFICATION

Client: UNIVERSITY MEDICAL CENTER

Client Account #: 3209283

Account #: 810768-NC1

Principal Balance: \$ 58.27

Accrued Interest: \$ 6.90

Amount Due: \$ 65.17

Dear SALLY RYAN:

Your insurance company has processed your claim. The above referenced amount/represents your patient liability.

To avoid further collection action, please remit the balance in full so that we may credit and close your account(s).

If you are not able to pay in full, please contact our office for an acceptable payment arrangement.

Thank you for your prompt attention in resolving this matter.

Respectfully,

CUSTOMER SERVICE (800) 337-4359
A Professional debt collector

This is an attempt to collect a debt and any information obtained will be used for that purpose.

AS REQUIRED BY LAW, YOU ARE HEREBY NOTIFIED THAT A CREDIT REPORT REFLECTING ON YOUR CREDIT RECORD MAY BE SUBMITTED TO A CREDIT REPORTING AGENCY IF YOU FAIL TO FULFILL THE TERMS OF YOUR OBLIGATIONS.

*I see they have
changed my account
number above.*

Print address/phone changes below:

Home ()
Work ()

Make your check or money order payable to:

HEALTHCARE RECOVERY SOLUTIONS
PO Box 51315

Los Angeles, CA 90051-1165



Detach And Return With Payment

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT	<input checked="" type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA
	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMEX
CARD NUMBER	EXP. DATE	
SIGNATURE		DATE
STATEMENT DATE 04-20-09		CURRENT BALANCE \$65.17
ACCOUNT # 810768-NC1		AMOUNT PAID \$

000513150000008107680000065174

I-BALAFINS

[illegible]

HEALTHCARE RECOVERY SOLUTIONS

1515 190th Street, Suite 350
Gardena, CA 90248-4910
Toll Free (800) 337-4359
Fax: (888) 663-6582

Office Hours - 8:30a.m. - 4:00 p.m. PST
Telephone Hours - Pacific Standard Time
Monday - Friday 8:00 a.m. - 4:30 p.m.

Tuser

ACCOUNT IDENTIFICATION
Client: UNIVERSITY MEDICAL CENTER
Client Account #: 3209283
Account #: 810768-14

Your account has been placed with our office for collection.

105,17
interest
10% per year

CUSTOMER SERVICE (800) 337-4359
Collector

--Detach And Return With Payment

Work ()

HEALTHCARE RECOVERY SOLUTIONS

Los Angeles, CA 90051-1165

41-NTCI

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW			
CHECK CARD USING FOR PAYMENT		<input checked="" type="checkbox"/> MASTERCARD <input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMEX	
CARD NUMBER	EXP. DATE	SIGNATURE	
		DATE	
		CURRENT BALANCE	AMOUNT PAID
		\$60.87	\$
		STATEMENT DATE 07-25-08	
		ACCOUNT #	
		810768-14	

MMDRSS14

SC DHHS - RECIP SPECIAL PROGRAM SUMMARY

09/24/10

RECIP NO: 6780804243

NAME: RYAN

SALLY

A

PCP:

LOCKIN BEGIN DATE: 09/01/09
ENTITY CD: SEEN BEFORE:

RECERTIFICATION DUE DATE:

HOSPICE DIAG:

PREG IND:

SEL	PGM	BEGIN	END	PROV#	BRD#	NHM#	CHC	DIS	DLU	USERID
-	MCHM	09/01/09	00/00/00	HM1000	Select Health		652		08/06/09	MAXE
-	MCHM	07/01/09	08/31/09	HM1600	Unison Health		652	35	08/06/09	MAXE
-	MCHM	06/01/08	06/30/09	HM1000	Select Health		651	35	05/28/09	MAXE
	END									

PAGE: 0001

** INFORMATION SUCCESSFULLY RETRIEVED **

PF1->HELP

PF6->RETURN

PF7->PAGE BACK

PF8->PAGE FORWARD

PF10->PREVIOUS MENU

PF11->PROV

PF13->DIAG INFO

elig = 11-01-07

AMDRSS02

SC DHHS - RECIPIENT INFORMATION

09/30/10

NAME: SALLY A RYAN
ADDR: APT G9 3628 MAYBANK HWY
JOHNS ISLAND
ZIP: 294554833

RECIP #: 6780804243 FAM #: 39849164
SSCN (MCN/RRN):

3628 MAYBANK HWY
JOHNS ISLAND

SSN: 073466781
SC COUNTY: 10
RSP IND: 1

PREFIX SSCN-MCN/RRN SUFFIX
LIV ARR: HOME QUAL CAT: 50
PAY CAT: 80

PAT NO: CUWKR

DSSDLU: 05/16/09

TPL: N FACIL: HH
VA: N RACE: 01 BIRTH: 07/06/1959
SEX: 2 DEATH: 00/00/00

HHSID: CLM20

HHSIDU: 06/28/08

POV: N ML DEP: 0

MEDICAID ELIG

INELIG

PAY Q

LS

BUYIN-B ST

ELIG

BUYIN-A ST

ELIG

CURR: 11/01/07

00/00/00

80

CURR: 0000

00/00

00/00

CURR: 0000 00/00 00/00

PRV1: 00/00/00

00/00/00

00/00/00

PRV1: 0000

00/00

00/00

PRV1: 0000 00/00 00/00

PRV2: 00/00/00

00/00/00

00/00/00

PRV2: 0000

00/00

00/00

PRV2: 0000 00/00 00/00

PRV3: 00/00/00

00/00/00

00/00/00

PRV3: 0000

00/00

00/00

PRV3: 0000 00/00 00/00

PRV4: 00/00/00

00/00/00

00/00/00

PRV4: 0000

00/00

00/00

PRV4: 0000 00/00 00/00

PRV5: 00/00/00

00/00/00

00/00/00

07/10

07/09

07/08

MOTHER RECIP#

PRV6: 00/00/00

00/00/00

00/00/00

06/11

06/10

06/09

06/09

PRV7: 00/00/00

00/00/00

00/00/00

AM

0

0

0

PRV8: 00/00/00

00/00/00

00/00/00

HH

0

0

0

ESRD:

REV IND:

CP

0

0

0

0

ALT RECIP ID:

MH

0

0

0

0

PF3->RSP SUMMARY

PF4->INQUIRY

PF5->FAMILY INFO

PF9->LIST SKEL CLAIMS

PF10->PREV MENU

PF11->LIST FAMILY MBRS

PF12->SKEL

CLM INFO PF14->MCR INFO

This beneficiary became eligible 11/1/07, however, she did not become enrolled in a MC Plan until 4/1/08 — The letter is about an ER visit on 2/13/08, when she was in fee-for-service.

MMDRSS14

SC DHHS - RECIP SPECIAL PROGRAM SUMMARY

09/24/10

RECIP NO: 6780804243

NAME: RYAN

SALLY

A

PCP:

LOCKIN BEGIN DATE: 09/01/09
ENTITY CD: SEEN BEFORE:

RECERTIFICATION DUE DATE:

HOSPICE DIAG:

PREG IND:

SEL	PGM	BEGIN	END	PROV#	BRD#	NHM#	CHC	DIS	DLU	USERID
-	MCHM	09/01/09	00/00/00	HM1000	Select Health		652		08/06/09	MAXE
-	MCHM	07/01/09	08/31/09	HM1600	Unison Health		652	35	08/06/09	MAXE
-	MCHM	06/01/08	06/30/09	HM1000	Select Health		651	35	05/28/09	MAXE
	END									

Das 2/13/08

PAGE: 0001

** INFORMATION SUCCESSFULLY RETRIEVED **

PF1->HELP

PF6->RETURN

PF7->PAGE BACK

PF8->PAGE FORWARD

PF10->PREVIOUS MENU

PF11->PROV

PF13->DIAG INFO

elig = 11-01-07



October 18, 2010

Ms. Sally Ann Ryan
3628 Maybank Highway, Apartment G-9
Johns Island, South Carolina 29455

Dear Ms. Ryan:

The South Carolina Department of Health and Human Services (SCDHHS) is in receipt of your letter to the Director of South Carolina Medicaid concerning claims from your visit to Arizona in February 2008. With your letter, you included copies of bills dated from April to July 2008.

In order for South Carolina Medicaid to cover emergency services rendered to recipients outside of the South Carolina Medicaid Service Area (SCMSA), the medical provider must accept Medicaid coverage and agree to credential with SCDHHS for payment to be made. The policy for timely submission and payment of claims is one year from the date of service.

The bills indicate that you were accepted as a self pay patient with no insurance coverage. Unfortunately, it appears that the providers in Arizona did not accept the South Carolina Medicaid coverage when the services were done, and the date of service is now past the timely filing limits, therefore you are responsible for the bills.

If you have any additional questions about this letter or need further assistance, please contact Mr. William Feagin, Team Leader in the Division of Pharmacy, Durable Medical Equipment (DME) & Physician Services, at (803) 898-2660.

Sincerely,




Melanie "BZ" Giese, RN
Bureau Director of Health Services

MG/gws

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>9-23-10</i>
--------------------	------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>100138</i>	<input type="checkbox"/> I Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR 	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>10-4-10</i> DATE DUE _____ <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.			

From: Sally Ann Ryan

3628 Maybank Highway
Apartment G9

Johns Island, SC 29455

08-09-10

RECEIVED

SEP 23 2010

TO: Director of Department of Health & Human Services
OFFICE OF THE DIRECTOR Carolina

I am getting calls from a collection agency about these bills. The bills are for, while visiting Arizona I ran out of some important medicines for on for psoriatic arthritis in my spine and s.t. joints. I called every doctor, clinic, and walk-in place, and they could not take me. That was on the advice of my doctor back home in S. Carolina at MUSC Rutledge Tower, 8th Floor, Dr. Sandhu, or the attending physician of the day there. So, I ended up in the E.R. at Tucson, Arizona UMC Hospital. First they took me in a room to find out about payment. I showed them my insurance cards, they copied them and made some phone calls. Then they said OK, go ahead and be seen here, the bill will be all taken care of. I have a very

Severe, special disease, and really can not travel any more after this happened. I called my doctors office several times, begging them to write a letter to Medicaid. I wrote them a letter, and they gave me my chart back when I moved to

Johns Island, closer to doctors. I found my original better, and the enclosed copies of my Tucson bills.

They never did anything about it. Dr. Sandhu did this on purpose because I complained to the hospital about her hitting me, and nothing was done about that either. Thank You Sally Ryan (843) 789-3048

Change of Name, Address or Insurance Coverage

1. Patient Information			
Last Name	First Name	M	
Ryan	Sally	Ahn	
Street Address	308 Mybank Hwy, Apt. G-9 (843) 789-3048		
City	State	Zip Code	Telephone Number
Johns Island, SC	29435		
2. Medicare			
ID #	<input type="checkbox"/> Primary Ins.	<input type="checkbox"/> Secondary Ins.	
Part A - Hospital Ins.	<input type="checkbox"/> Effective Date		
Part B - Physician Ins.	<input type="checkbox"/> Effective Date		
3. Medicaid			
<input checked="" type="checkbox"/> Primary Ins.	<input type="checkbox"/> Secondary Ins.		
Name on Card	Effective Date		
Sally A. Ryan	Oct '07		
a. State ID #	Program ID #		
6780804343			
b. City of	ID #		
Johns Island			
4. Other Coverage - Primary			
<input type="checkbox"/> Managed Medicare	<input checked="" type="checkbox"/> Managed Medicaid	Effective Date	
Insurance Co. Name	First Choice by Select Health of SC	3 Oct '07	
Insurance Co. Street Address	P.O. Box 7180		
Insurance Co. City/State/zip	London KY 40792		
Subscriber's Name	Sally A. Ryan		
ID #	40593879	Group #	
5. Other Coverage - Secondary			
<input type="checkbox"/> Managed Medicare	<input type="checkbox"/> Managed Medicaid	Effective Date	
Insurance Co. Name			
Insurance Co. Street Address			
Insurance Co. City/State/zip			
Subscriber's Name			
ID #		Group #	

I'm not sure *** If possible, please enclose a front & back copy of your Insurance ID Card with this change *** which one is Primary and Secondary.

STATEMENT OF MEDICAL SERVICES

To the Hospital - you can call Ins. Co. @ (803) 898-2660 @ 1-888-809-3040 for verification.

I sat 5 hours in your E.R. waiting to be seen first in an office where you verify payment. ~~They~~ You said I was all covered. I would never have bothered you but tried to get an appointment, but NO doctors in the area were taking any new patients, and even walk-in places were too full, and clinics. So this was about to be an emergency and I was glad to see you were open. I needed the fentanyl patch, and Lyrica for to treat my psoriatic arthritis in spine and S.I. joints, and lots of nerve damage I will have my primary-care Dr. Sandhu at MUSC in Charleston, S.C. call you. Thank You.

They would NOT ever call, Sally Ryan
 AS There are 2 separate bills, one for the hospital's emergency room, the other is for the physician.

to Dr. Sandy on Allen
I also need someone to
Contact ~~1-800-607-5666~~ ¹⁻⁸⁰⁰⁻³³³⁻⁵⁹
about a bill I had from when
I was in Arizona in Tucson
on 02-13-08. I had to go to
the Emergency Room at UMC Hospital
Because I needed the Duragesic Patch 25
and Lyrica 200 mg. There were NO doctors
that could take anyone, even drop-ins.
So therefore, I need you
to tell them it was an
emergency. Thank You Sally
To get medicine at the E.R. 07-06-1959

All the other doctors
clinics, and
walk-ins
were full.



☒ YOUR CURRENT INSURANCE IS LISTED BELOW. CHECK THIS BOX IF YOUR ADDRESS OR INSURANCE HAS CHANGED AND MAKE CHANGES ON REVERSE SIDE.

1. UNINSURED SELF PAY

2. NONE

MAIL PAYMENT TO:
UNIVERSITY EMERGENCY PHYSICIANS
PO BOX 29681
PHOENIX, AZ 85038-9681

(AS OF MAY 5, 2008)

PAGE 1

THE FOLLOWING INVOICES DESCRIBE OUTSTANDING CHARGES FOR SERVICES RENDERED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS AT UNIVERSITY PHYSICIANS HEALTHCARE. THE LEFT SIDE DESCRIBES THE SERVICES PROVIDED AND THE CHARGES FOR EACH SERVICE. THE RIGHT SIDE DESCRIBES PAYMENTS, ADJUSTMENTS, INSURANCE FILINGS, AND THE AMOUNT YOU OWE.

PAYMENT ACTIVITY

7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844

EMERGENCY MEDICINE

02/13/08 99203/GC-OFFICE VISIT

DIAGNOSIS CODE: 338.29, 785.0, 787.91

.....	\$242.00
TOTAL:	\$242.00

PAYMENT ACTIVITY	
02/13/08 TOTAL CHARGES	\$242.00
AMOUNT DUE NOW	\$242.00

NOTE: NO INSURANCE CLAIM WAS FILED FOR THIS SERVICE. IF YOU HAVE INSURANCE THAT COVERS THIS SERVICE, PLEASE CALL OUR OFFICE AT 520-874-7200 OR 866-467-2581.

OUR CORPORATE OFFICE IS NOW LOCATED AT 2701 E ELVIRA RD. TUCSON, AZ 85706. IF YOU HAVE ANY QUESTIONS PLEASE CALL 520-874-7200 OR TOLL FREE AT 866-467-2581. OUR OFFICE HOURS ARE 9:00AM TO 4:00PM MONDAY THROUGH FRIDAY.

THE BALANCE OF YOUR ACCOUNT IS PAST DUE AND PAYMENT IS DUE NOW. IF PAYMENT IN FULL IS NOT RECEIVED WITHIN 10 DAYS, YOUR ACCOUNT MAY BE REFERRED TO A COLLECTION AGENCY. FAILURE TO MAKE IMMEDIATE PAYMENT MAY IMPACT YOUR CREDIT RECORD.

Bill for Doctors at ER,
at University Medical Center
1501 N. Campbell Ave.
Tucson, Az 85724

AMOUNT DUE NOW: \$242.00



PRIORITY NOTICE

ACCOUNT IDENTIFICATION

3161245

[illegible]

Acetate

242,00 he said
Spoke 2 Bruce Myers
Myer ~~Myers~~
from Sun

YOU ARE HEREBY ADVISED

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will: obtain verification of the debt or obtain a copy of a judgement and mail you a copy of such judgement or verification. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

-----**Detach and Return with Payment**-----

Employer: _____

Address: _____

City, State, Zip: _____



IF PAYING BY CREDIT CARD FILL OUT BELOW

IF PAYING BY CREDIT CARD, FILL OUT BELOW

 ☐  ☐

MASTERCARD VISA

11
 12
 13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25
 26
 27
 28
 29
 30
 31
 32
 33
 34
 35
 36
 37
 38
 39
 40
 41
 42
 43
 44
 45
 46
 47
 48
 49
 50
 51
 52
 53
 54
 55
 56
 57
 58
 59
 60
 61
 62
 63
 64
 65
 66
 67
 68
 69
 70
 71
 72
 73
 74
 75
 76
 77
 78
 79
 80
 81
 82
 83
 84
 85
 86
 87
 88
 89
 90
 91
 92
 93
 94
 95
 96
 97
 98
 99
 100
 101
 102
 103
 104
 105
 106
 107
 108
 109
 110
 111
 112
 113
 114
 115
 116
 117
 118
 119
 120
 121
 122
 123
 124
 125
 126
 127
 128
 129
 130
 131
 132
 133
 134
 135
 136
 137
 138
 139
 140
 141
 142
 143
 144
 145
 146
 147
 148
 149
 150
 151
 152
 153
 154
 155
 156
 157
 158
 159
 160
 161
 162
 163
 164
 165
 166
 167
 168
 169
 170
 171
 172
 173
 174
 175
 176
 177
 178
 179
 180
 181
 182
 183
 184
 185
 186
 187
 188
 189
 190
 191
 192
 193
 194
 195
 196
 197
 198
 199
 200
 201
 202
 203
 204
 205
 206
 207
 208
 209
 210
 211
 212
 213
 214
 215
 216
 217
 218
 219
 220
 221
 222
 223
 224
 225
 226
 227
 228
 229
 230
 231
 232
 233
 234
 235
 236
 237
 238
 239
 240
 241
 242
 243
 244
 245
 246
 247
 248
 249
 250
 251
 252
 253
 254
 255
 256
 257
 258
 259
 260
 261
 262
 263
 264
 265
 266
 267
 268
 269
 270
 271
 272
 273
 274
 275
 276
 277
 278
 279
 280
 281
 282
 283
 284
 285
 286
 287
 288
 289
 290
 291
 292
 293
 294
 295
 296
 297
 298
 299
 300
 301
 302
 303
 304
 305
 306
 307
 308
 309
 310
 311
 312
 313
 314
 315
 316
 317
 318
 319
 320
 321
 322
 323
 324
 325
 326
 327
 328
 329
 330
 331
 332
 333
 334
 335
 336
 337
 338
 339
 340
 341
 342
 343
 344
 345
 346
 347
 348
 349
 350
 351
 352
 353
 354
 355
 356
 357
 358
 359
 360
 361
 362
 363
 364
 365
 366
 367
 368
 369
 370
 371
 372
 373
 374
 375
 376
 377
 378
 379
 380
 381
 382
 383
 384
 385
 386
 387
 388
 389
 390
 391
 392
 393
 394
 395
 396
 397
 398
 399
 400
 401
 402
 403
 404
 405
 406
 407
 408
 409
 410
 411
 412
 413
 414
 415
 416
 417
 418
 419
 420
 421
 422
 423
 424
 425
 426
 427
 428
 429
 430
 431
 432
 433
 434
 435
 436
 437
 438
 439
 440
 441
 442
 443
 444
 445
 446
 447
 448
 449
 450
 451
 452
 453
 454
 455
 456
 457
 458
 459
 460
 461
 462
 463
 464
 465
 466
 467
 468
 469
 470
 471
 472
 473
 474
 475
 476
 477
 478
 479
 480
 481
 482
 483
 484
 485
 486
 487
 488
 489
 490
 491
 492
 493
 494
 495
 496
 497
 498
 499
 500
 501
 502
 503
 504
 505
 506
 507
 508
 509
 510
 511
 512
 513
 514
 515
 516
 517
 518
 519
 520
 521
 522
 523
 524
 525
 526
 527
 528
 529
 530
 531
 532
 533

IF PAYING BY CREDIT CARD, FILL OUT BELOW			
 MASTERCARD		 VISA	
CARD NUMBER	AMOUNT		
SIGNATURE	EXP. DATE		
ACCOUNT #	CREDITOR	TOTAL AMOUNT DUE	AMOUNT PAID
3161245	University Physicians	\$250.36	
	1531723 16326297		



University Medical Center
1501 N. Campbell Ave.
Tucson, AZ 85724



HOSPITAL MONTHLY STATEMENT

Statement Date:

04/28/08

RETURN SERVICE REQUESTED

520-622-1974

0101

*Statement date
04-28-08*

Medical Record Number:

15317233

Payment Due Date:

05/23/08

Date(s) of Service:

02/13/08

Primary Insurance:

Policy #:

PENDING AHCCCS

073466781

Secondary Insurance:

Policy #:

UNINSURED SELF PAY

RYAN, SALLY
1020 CHARITY CHURCH RD
HUGER, SC 29450-9517

Page 1 of 2

University Medical Center appreciates your business!

Account Summary (please refer to detail on back)

Total hospital charges	\$ 250.00
Adjustments to date	\$ -191.73
Amount pending from insurance	\$ 0.00
Already paid by insurance	\$ 0.00
Already paid by patient	\$ 0.00
Amount you owe now	\$ 58.27

Please review the above information for accuracy.

If your information needs to be changed, you have a billing question, or you would like to request an itemized bill please contact our Customer Service Team at 520-622-1974, 1-800-874-4708, or customerservice@umcaz.edu

Our Business Office hours are Monday - Friday 8:00 a.m. to 5:00 p.m.

Message... Pay your bill online anytime at www.umcaz.com then click on For Patients.

The purpose of this statement is to notify you of the status of your open hospital accounts. We would appreciate payment in full of the \$58.27. If you are unable to pay this amount in full and would like to set up a budget payment plan, please contact our Customer Service Team at the numbers listed below.

Detach and return with payment. Please make checks payable to University Medical Center and write your account number(s) on the check.

951448 (07/06)

Statement Date:

04/28/08

RYAN, SALLY

33815

Please indicate below which account(s) you are paying.

☐ 3209283 58.27

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER

EXP. DATE (e.g. 11/05)

CARDHOLDER SIGNATURE

CARDHOLDER PRINTED NAME

3-DIGIT SECURITY CODE

Don't cut off card

DUE DATE

05/23/08

AMOUNT YOU OWE

\$ 58.27

MED RECORD NUMBER

15317233

Phone: Customer Service Team

Open 8:00 AM - 5:00 PM Monday - Friday
520-622-1974 or 1-800-874-4708

AMOUNT AUTHORIZED / ENCLOSED \$

☐ Please check box if address above is incorrect or insurance information has changed, and indicate change(s) on reverse side.

UNIVERSITY MEDICAL CENTER
P.O. BOX 840334
DALLAS, TX 75284-0334

[illegible]

HEALTHCARE RECOVERY SOLUTIONS

Fax: (888) 663-6582

Office Hours - 8:30a.m. - 4:00 p.m. PST
Telephone Hours - Pacific Standard Time
Monday - Friday 8:00 a.m. - 4:30 p.m.

1000
 900
 800
 700
 600
 500
 400
 300
 200
 100
 0
 100
 200
 300
 400
 500
 600
 700
 800
 900
 1000
 1100
 1200
 1300
 1400
 1500
 1600
 1700
 1800
 1900
 2000
 2100
 2200
 2300
 2400
 2500
 2600
 2700
 2800
 2900
 3000
 3100
 3200
 3300
 3400
 3500
 3600
 3700
 3800
 3900
 4000
 4100
 4200
 4300
 4400
 4500
 4600
 4700
 4800
 4900
 5000
 5100
 5200
 5300
 5400
 5500
 5600
 5700
 5800
 5900
 6000
 6100
 6200
 6300
 6400
 6500
 6600
 6700
 6800
 6900
 7000
 7100
 7200
 7300
 7400
 7500
 7600
 7700
 7800
 7900
 8000
 8100
 8200
 8300
 8400
 8500
 8600
 8700
 8800
 8900
 9000
 9100
 9200
 9300
 9400
 9500
 9600
 9700
 9800
 9900
 10000

Client: UNIVERSITY MEDICAL CENTER

Account #: 810768-NC1

58.27

~~6.90~~

65.17

Your insurance company has processed your claim. The above referenced amount/represents your patient liability.

To avoid further collection action, please remit the balance in full so that we may credit and close your account(s).

If you are not able to pay in full, please contact our office for an acceptable payment arrangement.

Thank you for your prompt attention in resolving this matter.

Respectfully,

CUSTOMER SERVICE (800) 337-4359
A Professional debt collector

This is an attempt to collect a debt and any information obtained will be used for that purpose.

AS REQUIRED BY LAW, YOU ARE HEREBY NOTIFIED THAT A CREDIT REPORT REFLECTING ON YOUR CREDIT RECORD MAY BE SUBMITTED TO A CREDIT REPORTING AGENCY IF YOU FAIL TO FULFILL THE TERMS OF YOUR OBLIGATIONS.

-Detach And Return With Payment

Print address/phone changes below:

Home ()	
Work ()	

Make your check or money order payable to:

HEALTHCARE RECOVERY SOLUTIONS
PO Box 51315

Los Angeles, CA 90051-1165

[illegible]

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW			
CHECK CARD USING FOR PAYMENT		<input checked="" type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA <input type="checkbox"/> AMEX
CARD NUMBER		EXP. DATE	
SIGNATURE		DATE	
STATEMENT DATE	CURRENT BALANCE	AMOUNT PAID	
04-20-09	\$65.17	\$	
ACCOUNT #			

I see they have changed my account number above.

000513150000008107680000065174

1-BALAFINS

4 Ryan
, Maybank Hwy.
G-9
Island, SC
29435



Medicaid Director

P.O. Box 8206

Columbia, S. Carolina

RECEIVED

SEP 23 2010

Department of Health & Human Services
OFFICE OF THE DIRECTOR

29002

