Val

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / ~~Goose~~ Hamilton	9-23-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-138	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[X] Prepare reply for appropriate signature DATE DUE 10-4-10
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

Cleared 10/18/10, letter attached

Brenda - 10/20/10
Close log - See attached letter. Thanks Annie

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.	10/07/10		
2. BS Grim	10/19 OK BZ	10/5 10/15	comment and commas
3. Val William	10-18-10 ~~10-13-10~~		
4.			

RECEIVED
SEP 30 2010
DIVISION OF CARE MANAGEMENT

RECEIVED
Dept. of Health & Human Services
SEP 28 2010 SEP 23 2010
BUREAU OF CARE MAN.
Bureau of Health Services

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

08-09-10

TO: Director of ~~MEDICAID~~ SCarolina

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 I'm on for psoriatic arthritis in my spine and S.I. 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 letter, 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: Ryan | First Name: Sally | M: Ann

Street Address: 3238 Maybank Hwy, Apt. G 9 | Telephone Number: (843) 789-3048

City: Johns Island | State: SC | Zip Code: 29455

2. Medicare ☐ Primary Ins. ☐ Secondary Ins.

ID #

Part A - Hospital Ins. ☐ Effective Date

Part B - Physician Ins. ☐ Effective Date

3. Medicaid ☒ Primary Ins. ☐ Secondary Ins.

Name on Card: Sally A. Ryan | Effective Date: Oct '07

a. State ID #: 67808043 43 | Program ID #

b. City of: Johns Island | ID #

4. Other Coverage - Primary

☐ Managed Medicare ☒ Managed Medicaid | Effective Date: ? Oct. '07

Insurance Co. Name: First Choice by Select Health of SC.

Insurance Co. Street Address: P.O. Box 7120

Insurance Co. City/State/Zip: London KY. 40742

Subscriber's Name: Sally A. Ryan

ID #: 405938777 | Group #

5. Other Coverage - Secondary

☐ Managed Medicare ☐ Managed Medicaid | Effective Date

Insurance Co. Name

Insurance Co. Street Address

Insurance Co. City/State/Zip

Subscriber's Name

ID # | Group #

*** If possible, please enclose a front & back copy of your Insurance ID Card with this change ***

I'm not sure which one is primary and secondary.

STATEMENT OF MEDICAL SERVICES

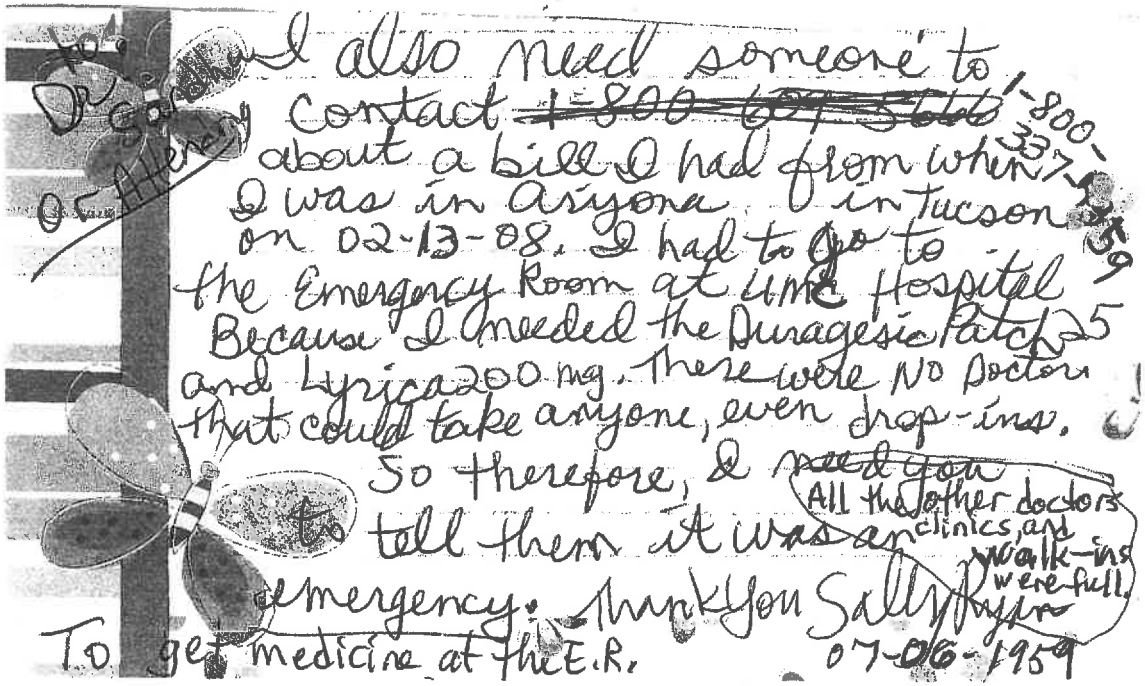
To the Hospital - you can call Ins. Co. @ (803) 898-2600 (OR) 1-888-809-3040 for verification.

I sat 5 hours in your E.R. waiting to bee 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. Sanghu at MUSC in Charleston, S.C. call you.

Thank You,

They would NOT ever call, Sally Ryan

PS→There are 2 separate bills, one for the Hospitals emergency room, the other is for the physician.



To: Dr. Sandoval or Attorney

I also need someone to contact ~~1-800-607-5666~~ 1-800-337-1359 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 Kyan

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

To get medicine at the E.R. 07-06-1959

UPH
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
HUGER, SC 29450-9517

2328 MB 0.360 AMECH

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 $242.00
TOTAL: $242.00

DIAGNOSIS CODE: 338.29, 785.0, 787.91

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

PRIORITY NOTICE

June 18, 2008

Surety Acceptance Corporation
(520) 790-7181

ACCOUNT IDENTIFICATION

Creditor: University Physicians
and 15317233 16326297
Account Number : 3161245
Total Due : $250.36

Acct# with Surety Corp
242.00 he said
spoke 2 Bruce ~~Meyers~~ Myer from Sur

Sally Ryan 3161245
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

Change of Address: _____

City, State, Zip: _____

Telephone: _____

Employer: _____

Address: _____

City, State, Zip: _____

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			
MASTERCARD ☐ VISA ☐			
CARD NUMBER			AMOUNT
SIGNATURE			EXP. DATE
ACCOUNT #	CREDITOR	TOTAL AMOUNT DUE	AMOUNT PAID
3161245	University Physicians 15317233 16326297	$250.36	

CBA 000066P 1 029 000039 171 062800 S-NOCRE

UMC
UNIVERSITY MEDICAL CENTER
Tucson, AZ

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

0101

RETURN SERVICE REQUESTED

520-622-1974

Statement date
04-28-08

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

HOSPITAL MONTHLY STATEMENT

Statement Date: 04/28/08

RYAN,SALLY

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	

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 (on back of card)

DUE DATE	AMOUNT YOU OWE	MED RECORD NUMBER
05/23/08	$ 58.27	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

33815*SCYOLM6TU000579

810768-NC1 - 033446768
PO BOX 19785
IRVINE CA 92623-9785

HRS-1-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 S RHETT 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.

I see they have changed my account number above.

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

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER	EXP. DATE
SIGNATURE	DATE

STATEMENT DATE	CURRENT BALANCE	AMOUNT PAID
04-20-09	$65.17	$

ACCOUNT # 810768-NC1

1-BALAFINS

00051315000000810768000006517 4

810768-14 - 31222821
PO BOX 19785
IRVINE CA 92623-9785

Address Service Requested

07-25-08

This is where I lived when I traveled to Tucson

Tucson

#BWNHPGX
#312228210#
SALLY RYAN 810768-14
1020 CHARITY CHURCH RD
HUGER, SC 29450-9517

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.

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

Principal Balance:	$	58.27
Accrued Interest:	$	2.60
Amount Due:	$	60.87

Dear SALLY RYAN:

Your account has been placed with our office for collection.

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 judgment and mail you a copy of such judgment 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.

You may CONTACT US at the address above, or by calling us at (800) 337-4359.

65.17
interest 10% per year

CUSTOMER SERVICE (800) 337-4359
Collector

Please Note: This communication is from a debt collector. This is an attempt to collect a debt and any information obtained will be used for that purpose.

----------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

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER	EXP. DATE
SIGNATURE	DATE

STATEMENT DATE	CURRENT BALANCE	AMOUNT PAID
07-25-08	$60.87	$

ACCOUNT #
810768-14

41-NTC1

00051315000000810768000006087 8

MMDRSS14 SC DHHS - RECIP SPECIAL PROGRAM SUMMARY 09/24/10

RECIP NO: 6780804243
NAME: RYAN SALLY A LOCKIN BEGIN DATE: 09/01/09
PCP: 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

```
1MDRSS02                SC DHHS  - RECIPIENT INFORMATION              09/30/10

 NAME: SALLY          A RYAN              RECIP #: 6780804243    FAM #: 39849164
 ADDR: APT G9                          SSCN (MCN/RRN):
       3628 MAYBANK HWY              SSN: 073466781     PREFIX SSCN-MCN/RRN SUFFIX
       JOHNS ISLAND             SC COUNTY:  10          LIV ARR: HOME  QUAL CAT: 50
 ZIP:  294554833                RSP IND: 1   TPL: N   FACIL: HH      PAY CAT: 80
 PAT NO: CUWKR    DSSDLU: 05/16/09              VA: N  RACE: 01 BIRTH: 07/06/1959
  HHSID: CLM20    HHSDLU: 06/28/08  POV: N ML DEP: 0   SEX: 2  DEATH: 00/00/00
 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           PRV1: 0000 00/00 00/00 PRV1: 0000 00/00 00/00
 PRV2: 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           PRV3: 0000 00/00 00/00 PRV3: 0000 00/00 00/00
 PRV4: 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                07/10      07/09   07/08  MOTHER RECIP#
 PRV6: 00/00/00 00/00/00                06/11      06/10   06/09
 PRV7: 00/00/00 00/00/00          AM       0          0       0
 PRV8: 00/00/00 00/00/00          HH       0          0       0
 ESRD:          REV IND:          CP       0          0       0
 ALT RECIP ID:                    MH       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 6/1/08 —

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 LOCKIN BEGIN DATE: 09/01/09
PCP: 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

DOS 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

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

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

Bureau of Health Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2868 • Fax (803) 255-8353

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	9-23-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-138	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ 	[X] Prepare reply for appropriate signature DATE DUE 10-4-10
	[ ] FOIA DATE DUE _____
	[ ] 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

TO: Director of DHHS S 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 I'm on for psoriatic arthritis in my spine and S.I. 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 letter, 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: Ryan | First Name: Sally | M: Ann

Street Address: 3208 Maybank Hwy, Apt. G9 | Telephone Number: (843) 789-3048

City: Johns Island | State: SC | Zip Code: 29455

2. Medicare ☐ Primary Ins. ☐ Secondary Ins.

ID #

Part A - Hospital Ins. ☐ Effective Date

Part B - Physician Ins. ☐ Effective Date

3. Medicaid ☒ Primary Ins. ☐ Secondary Ins.

Name on Card: Sally A. Ryan | Effective Date: Oct '07

a. State ID # 6780804243 | Program ID #

b. City of Johns Island | ID #

4. Other Coverage - Primary

☐ Managed Medicare ☒ Managed Medicaid | Effective Date: ? Oct. '07

Insurance Co. Name: First Choice by Select Health of S.C.

Insurance Co. Street Address: P.O. Box 7120

Insurance Co. City/State/Zip: London KY. 40792

Subscriber's Name: Sally A. Ryan

ID # 405938777 | Group #

5. Other Coverage - Secondary

☐ Managed Medicare ☐ Managed Medicaid | Effective Date

Insurance Co. Name

Insurance Co. Street Address

Insurance Co. City/State/Zip

Subscriber's Name

ID # | Group #

*** If possible, please enclose a front & back copy of your Insurance ID Card with this change ***

I'm not sure which one is primary and Secondary.

STATEMENT OF MEDICAL SERVICES

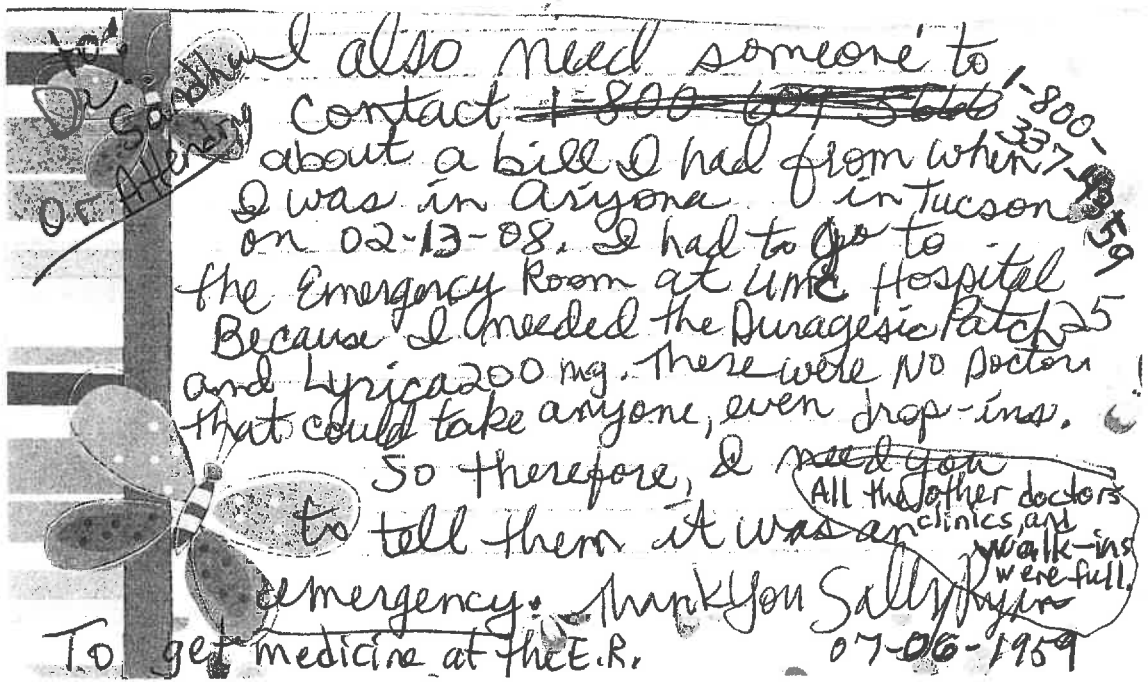
To the Hospital - you can call Ins. Co. @ (803) 898-2600 (OR) 1-888-809-3040 for verification.

I sat 5 hours in your E.R. waiting to bee 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. Sanghu at MUSC in Charleston, S.C. call you.

Thank You,

They would NOT ever call, Sally Ryan

PS→There are 2 separate bills, one for the Hospitals emergency room, the other is for the physician.



I also need someone to contact ~~1-800-607-5666~~ 1-800-337-3759 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 Kyler

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

To get medicine at the E.R. 07-06-1959

UPH

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
HUGER, SC 29450-9517

2328 MB 0.360 AMECH

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

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 $242.00
TOTAL: $242.00

DIAGNOSIS CODE: 338.29, 785.0, 787.91

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

PRIORITY NOTICE

June 18, 2008

Surety Acceptance Corporation
(520) 790-7181

ACCOUNT IDENTIFICATION

Creditor: University Physicians
and 15317233 16326297
Account Number : 3161245
Total Due : $250.36

Acct# w/ th Surety Corp
242.00 he said
spoke 2 Bruce Meyer from Surety

Sally Ryan 3161245
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

Change of Address: _____

City, State, Zip: _____

Telephone: _____

Make your check or money order payable to:

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

Employer: _____

Address: _____

City, State, Zip: _____

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 15317233 16326297	$250.36	

CBA 000066P 1 029 000039 171 062800 S-NOCRE

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

0101

RETURN SERVICE REQUESTED

520-622-1974

Statement date
04-28-08

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

HOSPITAL MONTHLY STATEMENT

Statement Date: 04/28/08

RYAN,SALLY

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	

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

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 | 3-DIGIT SECURITY CODE (on back of card)

CARDHOLDER PRINTED NAME

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

☐ 3209283 58.27

DUE DATE	AMOUNT YOU OWE	MED RECORD NUMBER
05/23/08	$ 58.27	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

33815*SCYOLM6TU000579

810768-NC1 - 033446768
PO BOX 19785
IRVINE CA 92623-9785

IRS-1-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 S RHETT 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.

I see they have changed my account number above.

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

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER	EXP. DATE
SIGNATURE	DATE

STATEMENT DATE	CURRENT BALANCE	AMOUNT PAID
04-20-09	$65.17	$

ACCOUNT # 810768-NC1

1-BALAFINS

00051315000000810768000006517 4

810768-14 - 31222821
PO BOX 19785
IRVINE CA 92623-9785

Address Service Requested

07-25-08

this is where I lived when I traveled to Tucson

Tucson

#BWNHPGX
#312228210#
SALLY RYAN 810768-14
1020 CHARITY CHURCH RD
HUGER, SC 29450-9517

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.

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

Principal Balance:	$	58.27
Accrued Interest:	$	2.60
Amount Due:	$	60.87

Dear SALLY RYAN:

Your account has been placed with our office for collection.

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 judgment and mail you a copy of such judgment 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.

You may CONTACT US at the address above, or by calling us at (800) 337-4359.

65,17
interest 10% per year

CUSTOMER SERVICE (800) 337-4359
Collector

Please Note: This communication is from a debt collector. This is an attempt to collect a debt and any information obtained will be used for that purpose.

----------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

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER	EXP. DATE
SIGNATURE	DATE

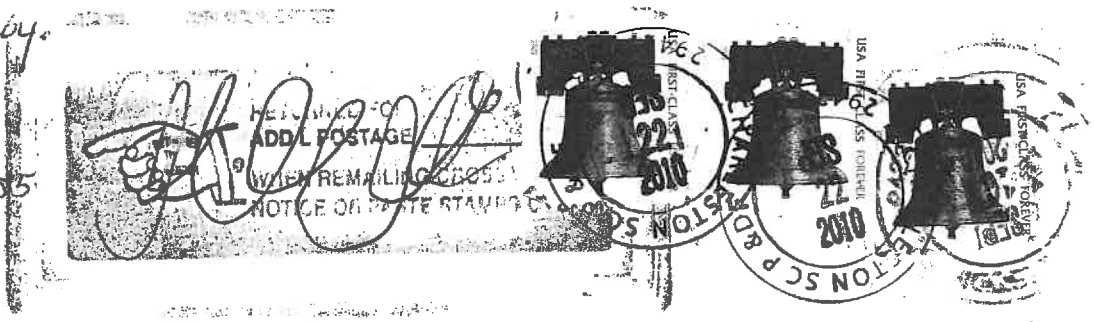
STATEMENT DATE	CURRENT BALANCE	AMOUNT PAID
07-25-08	$60.87	$

ACCOUNT #
810768-14

41-NTC1

00051315000000810768000060878

y Ryan
' Maybank Hwy.
G-9
Island, SC
29455



Medicaid Director
P. O. Box 8206
Columbia, S. Carolina
29002

RECEIVED
SEP 23 2010
Department of Health & Human Services
OFFICE OF THE DIRECTOR