DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	3-16-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 080505	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms. Forkner e-mail from Daisy attached Cleared 4/2/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 3-25-09 [ ] 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.			

Living With ADD

Daniel L. Moore, MD

2375 East Main Street, Suite A-311 • Spartanburg, SC 29307
864-579-3960 • 864-579-1368 (fax) • dlmsm@bellsouth.net

March 14, 2009

Ms. Emma Forkner, Director
S.C. Department of Health & Human Services
P.O. Box 8206
Columbia, S.C., 29202-8206

Dear Ms. Forkner,

I am writing to you in an attempt to clarify/rectify a recurring error in your processing of my claims on several children. I am a semi-retired, solo practitioner. My wife, Margaret, does most of the "paper work", including filing Medicaid claims. We have tried to follow the appropriate guidelines, but during the past 1 ½ years, have made no progress in resolving this situation (and other similar situations which I will review later).

My medical background/experience is in pediatric neurology & developmental pediatrics, predominantly caring for children with handicapping neurologic conditions (epilepsy, cerebral palsy and other neuromuscular disorders, autistic spectrum disorders, and ADHD and related/associated conditions). During the past 15+ years, I have progressively limited my practice to the evaluation/management of children and adults with ADD/ADHD. I still try to serve those with autism spectrum disorders and some multi-handicapped individuals (children and adults who "have grown up with me"); but I no longer care for patients with epilepsy.

I serve as a consultant at the McCarthy-Teszler School here in Spartanburg, a day school for children(to age 21) with special needs (predominantly physical disabilities and/or mental retardation and/or behavior disorders) which have limited them from functioning in a regular school environment. Most of my new Medicaid patients are from that situation.

I function as a "mom & pop" practice. We are not associated with any insurance organization, nor do we file any insurance claims except for Medicaid. We continue to use the CMS 1500 form to file our claims. During the transitions in recent years (utilizing NPI and taxonomy numbers in various spaces, etc.), we have had our share of rejected claims because of inaccurate placement and/or incomplete information—but I believe that my wife is having more success in recent months.

My main purpose in writing to you is to make another attempt to correct **errors made by your staff**. My first example is regarding **Haley Mosher Cannon**, ID # 9730931301, DOB 07-09-95. I am enclosing copies of the relevant communications. I have been caring for her since March '04 (and her twin brother Jesse since March '99). For her office visit of 10-25-07, I filed a charge of $90.00. As per the "remittance advice" sheet for payment date 11/09/2007, I was paid "0.90". My wife refilled the claim on 1/21/08 (we do not file claims until we have accumulated several). I saw Haley for re-evaluation on 2/08/08 and as we had no response, on 3/7/08 she filed a claim for both the 10/27/07 and the 2/08/08 visits. As per the "edit correction form" of "run date" 04/15/08, I again was paid 0.90 for the 10/27/07 visit and 0.65 (instead of 65) for the 2-08-08 visit = "1.55". She re-filed the claims on 4/30/08, submitting the corrected "edit " form with the CMS1500 form. As per "edit forms" of 5/20/08, 5/27/08, & 5/30/08 the claims are rejected as #852= "duplicate payment" from "payment date 11/09/07". I re-evaluated Haley on 12/22/08, but have deferred submitting a claim until this is resolved. To date, I have been paid 0.90 on 11/09/07 and 1.55 on 4/15/08.

In reviewing other unpaid Medicaid accounts, we have found several other similar situations. I will try to briefly summarize those mistakes.

Brandon Farr, DOB 7/22/94, Medicaid #2424546704, was initially evaluated on 9/25/07. The claim was submitted on 10/25/07 with our usual charge for an initial visit of $450.00. As per enclosed copies, we received "remittance advice" dated 11/09/2007, paying me $4.50. A claim was refilled on 1/21/08, to which we received the statement of 2/15/08 indicating that I had already been paid. That is correct—I was paid, but incorrectly; and the $9.00 check was returned to you. Attempts to correct this situation resulted in the same response on 7/22/08.

Joshua St.Clair, DOB10/31/96, Medicaid #2420446501, was initially evaluated on 10/2/07, for which I charged the usual fee of $450.00 (99245). A claim was filed on 10/25/07, for which we received the "remittance advice" of 11/09/2007, paying me $4.50 **(as you will note, all three of these payment errors were initially made on the statement of 11/09/2007).** The incorrect statement and the check for $9.00 (combined payment for Brandon Farr and Joshua St. Clair) was returned to your office. We have had no payment or response.

Michael Donnahoo, DOB 7/21/98, Medicaid # 1551986401, was seen on 11/18/08 for an extended re-evaluation (last evaluation was in October 2006) for which I charged $100.00 (99215). The claim was filed on 11/26/08. On "remittance advice" statement of 12/12/2008, I was paid only $1.00 (copies of these forms and check are enclosed). As per copy, on 12/13/08 we returned the statement and the $1.00 check to you, requesting that you make appropriate corrections and re-issue a new check in the proper amount. **We have had no response or payment!!**

I trust that this information will enable you to resolve these incorrect situations and pay me what is due me for providing medical care for these children. I will be out of the office during the week of 3/16-20/09, so I will look forward to hearing from you during the week of 3/23-27/09.

Sincerely,

Daniel L. Moore, MD

Daniel L. Moore, MD

LIVING WITH ADD
DAY AND NIGHT

DANIEL L. MOORE, MD

2375 E. MAIN STREET, SUITE A-311
SPARTANBURG, SC 29307

TEL: 864-579-3960 FAX: 864-579-1368

dlmsm@bellsouth.net

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☑ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 993093501

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [illegible]

3. PATIENT'S BIRTH DATE MM DD YY: 07 09 95 — SEX M ☐ F ☑

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

ZIP CODE — TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

(Attached note:)
① 1/09
This is a "Copy" of the original Claim dated 10/27/07 in Amount of $90.00 chg.

Daytrana
[methylphenidate transdermal system]
Please see accompanying Full Prescribing Information including boxed warning.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 10-25-07

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314. 9
2. 300. 3
3. 780. 52
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 25 07		11		99215		1,2,3	90			NPI	1942303185
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 570934008 — SSN ☐ EIN ☑

26. PATIENT'S ACCOUNT NO.: [illegible]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☑ YES ☐ NO

28. TOTAL CHARGE $ 90 —

29. AMOUNT PAID $

30. BALANCE DUE $ 90 —

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [illegible] DATE 10/26/07

32. SERVICE FACILITY LOCATION INFORMATION — a. — b.

33. BILLING PROVIDER INFO & PH # (864) 579-3960
[illegible]
[illegible] H-3
Spartanburg SC 29307
a. — b. 1D 080646

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

PROVIDER ID. 080646

000021103
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

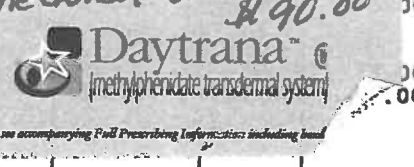
PAYMENT DATE 11/09/2007

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	RV	IND	SERVICE RENDERED DATE(S) MMDDYY	PROC	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
LANDRUMK	0729900693001400					00	0.00	R	7420547401	K R LANDRUM				
	01					00	0.00	R			000		0.00	0.00
	02					00	0.00	R			000		0.00	0.00
										EDITS: L00*943		L01*692		
										EDITS: L02*692		L02 989		
LONGMA	07299006940					00	73.00	P	9718623901	M A LONG				
						00	73.00	P			000		2.00	0.00
										EDITS: L00*943		L01*692		
BREWINGTO	072990069500					00	75.00	P	0780417930	H C BREWINGTON				
	0					00	75.00	P			000		0.00	0.00
										EDITS: L00*943		L01*692		
SEAGLEJ	0729900696001400					00	0.00	R	7470340202	J C SEAGLE				
	01					.00	0.00	R			000		0.00	0.00
										EDITS: L00 760		L00*943		
										EDITS: L01*692				
OBRIENBRA	0729900697001400A					100.00	94.00	P	4718277001	B W OBRIEN				
	01			102507	99215	100.00	94.00	P			000		2.00	0.00
										EDITS: L00*943		L01*692		
MULLINANE	0729900698001400A					450.00	178.42	P	5780753277	E MULLINAX				
	01			092607	99245	450.00	178.42	P			000		0.00	0.00
										EDITS: L00*943		L01*692		
MOSHER	0730210870021200A					130.00	130.00	P	5471223203	J M CANNON				
	01			062807	99214	65.00	65.00	P			000		0.00	0.00
	02			102507	99214	65.00	65.00	P			000		0.00	0.00
										EDITS: L00*943		L01*692		
										EDITS: L02*692				
MOSHER	0730210871021200A					0.90	0.90	P	9730931301	H M CANNON				
	01			102507	99215	0.90	0.90	P			000		0.00	0.00
										EDITS: L00*943		L01*692		

2/6/09

This is a "copy" of what Dr. Moore Recieved with a payment of "90 cents" - NOT the dollar amt. of $90.00



INCORRECT

Resent 3-5-08 Resent 4/30/08

$551.32

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT

CERTIFIED AMT

MEDICAID PG TOT

MEDICAID TOTAL

CHECK TOTAL

CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY/HABILI
2375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) ☑ | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 973193301

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Washer-Harvey

3. PATIENT'S BIRTH DATE MM DD YY: 07 19 95 SEX M ☐ F ☑

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 10-25-07

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314.9
2. 300.3
3. 080.50
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 25 07		11		99215		1,2,3	90 00			NPI	1942309185
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☑: 570734008

26. PATIENT'S ACCOUNT NO.: Washer H

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐

28. TOTAL CHARGE: $ 90 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file

SIGNED DATE 12/1/08

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (864) 579-3960

DANIEL MCCORMICK MD
220 S E MAIN ST H-311
GREENVILLE SC 29601

a. b. ID 0280646

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PROVIDER ID. 080646 | 000165122 DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/15/2008

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
FARRB	0802308136016900A 01		092507	99245	450.00	0.00	R	2424546704	B FARR	000		0.00	0.00
					450.00	0.00	R		EDITS: L00*943 EDITS: L01 852 11/09/07		L01*692		
MOSHERH	0802308137016900A 01		102507	99215	90.00	0.00	R	9730931301	H M CANNON	000		0.00	0.00
					90.00	0.00	R		EDITS: L00*943 EDITS: L01 852 11/09/07		L01*692		
	TOTALS		2		540.00	0.00						0.00	0.00

Already Paid - 0

$0.00

CERT. PG TOT: $0.00
MEDICAID PG TOT: $0.00
CERTIFIED AMT: $0.00
MEDICAID TOTAL: $0.00
$0.00
CHECK TOTAL

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY/HABILI
2375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) ✓ | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 923093/301

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cannon Haley

3. PATIENT'S BIRTH DATE MM DD YY: 07 09 95 SEX M ☐ F ✓

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [signature] DATE: 2/8/08

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L 314.9
2. L 300.3
3. L 780.50
4. L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 08 08				99214		1,2,3	65 -			NPI	1942303785
2 10 25 07				99215		1,2,3	90 -			NPI	1942303785
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ✓: 510934009

26. PATIENT'S ACCOUNT NO.: CANNON H

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO ☐

28. TOTAL CHARGE $ 155 -

29. AMOUNT PAID $

30. BALANCE DUE $ 155 -

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

[signature] SIGNED DATE 3/9/08

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (864) 547-3760

[illegible] a. b. ID 0906146

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

RUN DATE 04/15/2008 000154991
REPORT NUMBER CLM3500
ANALYST ID LATEC
SIGNON ID LATEJ

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 22

CLAIM CONTROL #0808505124011800A
PAGE 18809 ECF 18809 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

TAXONOMY:
SFL ZIP:
PRV ZIP: 29307
DOC IND Y

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
080646	9730931301						314.9	300.3

NPI:

Haley Mosher

10 RECIPIENT NAME - HALEY M CANNON

11 DATE OF BIRTH 07/09/1995 12 SEX F

13 RES	14 ALLOWED	15 LN NO	DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	02/08/08	11	99214	000	080646	65.00		1.000
	NPI: 1942303185		TAXONOMY:							
	.00	2	10/25/07		99215	000	080646	90.00		1.000
	NPI: 1942303185		TAXONOMY:							
		3	/ /							
	NPI:		TAXONOMY:							
		4	/ /							
	NPI:		TAXONOMY:							
		5	/ /							
	NPI:		TAXONOMY:							
		4	/ /							
	NPI:		TAXONOM							
	NPI:									
	NPI:									

23 NDC

NOT Paid

LINE EDITS
01) 234
02) 234 852

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
! 02-852 11/09/07 !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

EDITS
INSURANCE EDITS

CLAIM EDITS
943

24 INS CARR NUMBER

01
02
03

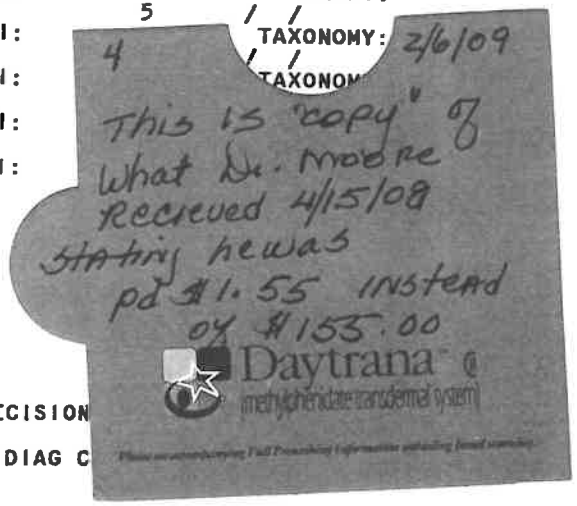
RESOLUTION DECISION

ADDITIONAL DIAG C

27 TOTAL CHARGE 155.00
28 AMT REC'D INS .00
29 BALANCE DUE 1.55
30 OWN REF # CANNONH

Bal. due 155.00

4 2/6/09
This is "copy" of what Dr. Moore Received 4/15/08
Stating he was pd $1.55 instead of $155.00



RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Sent 4/30/08

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID ✓ (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 973073131C1

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Masher Haley

3. PATIENT'S BIRTH DATE MM DD YY: 07 09 95 — SEX: M | F ✓

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M | F

b. AUTO ACCIDENT? YES | NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 10-25-07

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate

1. 314 9

2. 300 3

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

R AUTHORIZATION NUMBER

Daytana — methylphenidate hydrochloral system — 2409

4/30/08 Claim was Refiled for 10/25/07 90.00 — Not pd. And for 65.00 2/8/08 for 155.00 Partial Chg.

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 25 07		11		90 —			NPI 1942303185
2	12 08 08		11		65 —			NPI 1942303185
3								NPI
4								NPI
5								NPI
6								NPI

25. FEDERAL TAX I.D. NUMBER: 590934008 — SSN | EIN ✓

26. PATIENT'S ACCOUNT NO.: Masher H

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ | NO

28. TOTAL CHARGE: $ 155 —

29. AMOUNT PAID: $

30. BALANCE DUE: $ 155 —

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

David L Moore MD 4/30/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (864) 509-3960

David L Moore MD A-311
[illegible] Dr Ste A-311
Spartanburg SC 29307

a. b. ID080646

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

RUN DATE 05/20/2008 000153233 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
REPORT NUMBER CLM3500 EDIT CORRECTION FORM
ANALYST ID PROV HIC - 20 PRAC SPEC - 22
SIGNON ID MARLR DOC IND Y
TAXONOMY: SFL ZIP: PRV ZIP: 29307

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
080646	9730931301						314.9	300.3

NPI:

CLAIM CONTROL #08023081370169O0A
PAGE 13215 ECF 13215 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 852

10 RECIPIENT NAME - HALEY M CANNON 11 DATE OF BIRTH 07/09/1995 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	10/25/07	11	99215	000	080646		90.00	1.000

23 NDC

NPI: 1942303185 TAXONOMY: 2080P0006X
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

AGENCY USE ONLY
APPROVED EDITS
REJECTED LINE EDITS

CLAIMS/LINE PAYMENT INFO

EDIT 01-852 PAYMENT DATE 11/09/07

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID		
01			27 TOTAL CHARGE	90.00
02			28 AMT REC'D INS	.00
03			29 BALANCE DUE	90.00
			30 OWN REF #	MOSHERH

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Refer to Payment date: 11/9/07 and you will see that Dr. Moore was paid $.90 cents Not $90.00.

RUN DATE 05/27/2008 000127456 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0808505124011800A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 8700 ECF 8700 PAGE 1 OF 1
ANALYST ID PROD9 HIC - 20 PRAC SPEC - 22 EMC
SIGNON ID ROGEK DOC IND Y ORIGINAL CCN:
TAXONOMY: SFL ZIP: PRV ZIP: 29307 ADJ CCN:

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	9 SECONDARY
080646	9730931301						314.9	300.3

NPI:

EDITS
INSURANCE EDITS

CLAIM EDITS
943 NPI # required

LINE EDITS
02) 852 duplicate pay

10 RECIPIENT NAME - HALEY M CANNON 11 DATE OF BIRTH 07/09/1995 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	02/08/08	11	99214	000	080646	65.00	1.000	
*	NPI: 1942303185		TAXONOMY: 2080P0006X							
	.00	2	10/25/07	11	99215	000	080646	90.00	1.000	
*	NPI: 1942303185		TAXONOMY: 2080P0006X							
	NPI:	3	/ / TAXONOMY:							
	NPI:	4	/ / TAXONOMY:							
	NPI:	5	/ / TAXONOMY:							
	NPI:	6	/ / TAXONOMY:							
	NPI:	7	/ / TAXONOMY:							
	NPI:	8	/ / TAXONOMY:							

23 NDC

AGENCY USE ONLY
APPROVED EDITS
REJECTED LINE EDITS

CLAIMS/LINE PAYMENT INFO

EDIT	PAYMENT DATE
02-852	11/09/07

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27	TOTAL CHARGE	155.00
28	AMT REC'D INS	.00
29	BALANCE DUE	155.00
30	OWN REF #	CANNONH

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Refer to Run date 4/15/08 and you will see that Dr. Moore was paid $1.55 for OV on: 10/25/07 - $90.00 02/08/08 $65.00

PROVIDER ID. 080646

000127455
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 05/30/2008

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
CANNONH	080850512401180OA				155.00	0.00	R	9730931301	H M CANNON				
	01		020808	99214	65.00	0.00	R			000		0.00	0.00
	02		102507	99215	90.00	0.00	R			000		0.00	0.00
									EDITS: L00 943		L01*692		
									EDITS: L02*692		L02 852	11/09/07	
	TOTALS		1		155.00	0.00						0.00	0.00

	CERT. PG TOT	MEDICAID PG TOT
		$0.00
	$0.00	$0.00
	CERTIFIED AMT	MEDICAID TOTAL
$0.00	$0.00	$0.00
		CHECK TOTAL

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID ✓ (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 242455[illegible]704

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Farr Bruha

3. PATIENT'S BIRTH DATE MM DD YY: 09 22 94 | SEX: M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete Item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [signature] DATE 9-25-09

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314.01

2. 309.28

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 25 09	11		99245		1	450	-		NPI	1942903185
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN | EIN: 56-0784608 ✓

26. PATIENT'S ACCOUNT NO.: Farr B.

27. ACCEPT ASSIGNMENT? (For govt claims, see back) ✓ YES | NO

28. TOTAL CHARGE $ 450

29. AMOUNT PAID $

30. BALANCE DUE $ 450 —

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] DATE 10/25/09

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (864) [illegible]-3960

a. b. [illegible]

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PROVIDER ID. 080646

000021104
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 11/09/2007

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
STCLAIRJR	0730210872021200A 01		100207	99245	4.50 4.50	4.50 4.50	P P	2420446501	J B ST CLAIR EDITS: L00*943	000	L01*692	0.00	0.00
FARRB	0730210873021200A 01		092507	99245	4.50 4.50	4.50 4.50	P P	2424546704	B FARR EDITS: L00*943	000	L01*692	0.00	0.00
		TOTALS	10		1054.90	560.32						0.00	0.00

$9.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$560.32
CERTIFIED AMT	MEDICAID TOTAL
$0.00	$560.32
	CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

5073284
CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY/HABILI
2375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID [✓] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 3H3 454 6 7714

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FARR BRANDON

3. PATIENT'S BIRTH DATE MM DD YY: 07 22 94 | SEX M [✓] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 9-25-07

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314.01 2. 309.28 3. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 25 07	11		99245		1,2	$ 450 00			NPI	20800000X 1942203185
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 590734008 | SSN | EIN [✓]

26. PATIENT'S ACCOUNT NO.: Farr B

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [✓] | NO

28. TOTAL CHARGE: $ 450 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 450 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Daniel L Moore MD 1/2/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (864) 579-3960

Daniel Moore MD
3325 E Main St H-3
Spartanburg SC 29307

a. b. ID080646

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PROVIDER ID. 080646

000165122
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/15/2008

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
FARRB	0802308136016900A 01		092507	99245	450.00 450.00	0.00 0.00	R R	2424546704	B FARR EDITS: L00*943 EDITS: L01 852 11/09/07	000	L01*692	0.00	0.00
MOSHERH	0802308137016900A 01		102507	99215	90.00 90.00	0.00 0.00	R R	9730931301	H M CANNON EDITS: L00*943 EDITS: L01 852 11/09/07	000	L01*692	0.00	0.00
	TOTALS		2		540.00	0.00						0.00	0.00

Already Paid - 0

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

$0.00 — CERTIFIED AMT

$0.00 — CERT. PG TOT

$0.00 — MEDICAID TOTAL

$0.00 — MEDICAID PG TOT

$0.00 — CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY/HABILI
2375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

RUN DATE 07/22/2008 000076726 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #08023081360169O0A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 7532 ECF 7532 PAGE 1 OF 1
ANALYST ID PROV HIC - 20 PRAC SPEC - 22 EMC
SIGNON ID MARLR DOC IND Y ORIGINAL CCN:
TAXONOMY: SFL ZIP: PRV ZIP: 29307 ADJ CCN:

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
080646	2424546704						314.01	309.28

NPI: 1942303185

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 852 Duplicate Pmt - wrong!

10 RECIPIENT NAME - BRANDON FARR 11 DATE OF BIRTH 07/22/1994 12 SEX M

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	09/25/07	11	99245	000	080646	450.00		1.000

23 NDC

NPI: 1942303185 TAXONOMY: 2080P0006X
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

AGENCY USE ONLY
APPROVED EDITS
REJECTED LINE EDITS

CLAIMS/LINE PAYMENT INFO
EDIT 01-852 PAYMENT DATE 11/09/07

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID		
01			27 TOTAL CHARGE	450.00
02			28 AMT REC'D INS	.00
03			29 BALANCE DUE	450.00
			30 OWN REF #	FARRB

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

PROVIDER ID. 1942303185

000076724
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 07/25/2008

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
FARRB	08023081360169 00A				450.00	0.00	R	2424546704	B FARR				
	01		092507	99245	450.00	0.00	R			000		0.00	0.00
									EDITS: L01 852 11/09/07				
SAWYERC	08085023960050 00A				85.00	85.00	P	7716796601	C W SAWYER				
	01		020708	99215	85.00	85.00	P			000		0.00	0.00
COOPERD	08085023970050 00A				75.00	73.00	P	1882039402	D L COOPER				
	01		030408	99215	75.00	73.00	P			000		2.00	0.00
SCHMIDTA	08085023980050 00A				100.00	98.72	P	6421912502	A L SCHMIDT				
	01		030408	99215	100.00	98.72	P			000		0.00	0.00
BROWNLEEG	08085023990050 00A				130.00	0.00	R	7428785305	G L BROWNLEE				
	01		080307	99214	65.00	0.00	R			000		0.00	0.00
	02		020808	99214	65.00	0.00	R			000		0.00	0.00
									EDITS: L01 953		L02 953		
MASHERJ	08085024000050 00A				65.00	65.00	P	5471223203	J M CANNON				
	01		020808	99214	65.00	65.00	P			000		0.00	0.00
BRANCHNAT	08085024010050 00A				100.00	98.72	P	4630192284	N L BRANCH				
	01		012208	99215	100.00	98.72	P			000		0.00	0.00
THREATTG	08085024020050 00A				100.00	98.72	P	1641692701	G S THREATT				
	01		020408	99215	100.00	98.72	P			000		0.00	0.00
LONGMA	08085024030050 00A				75.00	73.00	P	9718623901	M A LONG				
	01		021508	99215	75.00	73.00	P			000		2.00	0.00
FOSTERF	08085024040050 00A				80.00	78.00	P	6716614601	F L FOSTER				
	01		021908	99215	80.00	78.00	P			000		2.00	0.00
SULLIVANC	08085024050050 00A				100.00	96.72	P	9723382101	C W SULLIVAN				
	01		022908	99215	100.00	96.72	P			000		2.00	0.00

$766.88
CERT. PG TOT
MEDICAID PG TOT

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERTIFIED AMT
MEDICAID TOTAL
CHECK TOTAL
CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID [✓] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 242046-01

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): St. Clair Joan

3. PATIENT'S BIRTH DATE MM DD YY: 10 31 96 | SEX M [✓] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 10-2-06

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314.1
2. 343.0
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 02 06		11		99245			450			NPI	1942303185
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 570234008 [✓]

26. PATIENT'S ACCOUNT NO.: St. Clair J

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [✓] YES | NO

28. TOTAL CHARGE: $ 450 —

29. AMOUNT PAID: $

30. BALANCE DUE: $ 450 —

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 10/25/06

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (804) 549-3760

a. b. ID 090646

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PROVIDER ID. 080646

000021104
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 11/09/2007

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
STCLAIRJR	0730210872021200A 01		100207	99245	4.50 4.50	4.50 4.50	P P	2420446501	J B ST CLAIR EDITS: L00*943	000	L01*692	0.00	0.00
FARRB	0730210873021200A 01		092507	99245	4.50 4.50	4.50 4.50	P P	2424546704	B FARR EDITS: L00*943	000	L01*692	0.00	0.00
	TOTALS		10		1054.90	560.32						0.00	0.00

Incorrect

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

$0.00

CERT. PG TOT
$0.00

CERTIFIED AMT
$0.00

$9.00

MEDICAID PG TOT
$560.32

MEDICAID TOTAL
$560.32

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

5073284

CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY/HABILI
2375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) ☑ | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 155198640 1

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Donnehoo Michael

3. PATIENT'S BIRTH DATE MM DD YY: 07 21 98 | SEX: M ☑ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 11/18/08

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 314.01
2. 313.81
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 18 08	11		99215		1,2	100 —			ZZ NPI	2080P0006X 1943303185
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 510934008 | EIN ☑

26. PATIENT'S ACCOUNT NO.: Donnehoo M.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ | NO

28. TOTAL CHARGE: $ 100 —

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 —

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Daniel J Moore DATE 11/24/08

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # (864) 579-3960

Daniel J Moore

~~Daniel J Moore~~

432 E Main St H-311

Spartanburg SC 29302-14-34

a. 1943303185 b. ZZ2080P0006X

Living With ADD
Daniel L. Moore, MD
2375 East Main Street, Suite A-311 • Spartanburg, SC 29307
864-579-3960 • 864-579-1368 (fax) • dlmsm@bellsouth.net

12-13-08

Emma Forkner
Dept. of HHS
po Box 8206
Columbia SC
29202-8206

Dear Ms Forkner,

I am returning this check to you along with a copy of the original claim form so that you make make the appropriate corrections and re-issue a check in the appropriate amount.

thank you for prompt resolution of this situation.

Sincerely,
Daniel L. Moore, MD

PROVIDER ID. 1942303185

000034834
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 12/12/2008

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
DONNEHOOM	0833602316004700A 01		111808	99215	1.00	1.00	P	1551986401	M R DONNAHOO	000		0.00	0.00
					1.00	1.00	P					0.00	0.00
	TOTALS		1		1.00	1.00						0.00	0.00

SOUTH CAROLINA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
COLUMBIA. S.C.

67-1
532

5286501

PAY TO THE ORDER OF

1942303185
DANIEL L MOORE MD
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307

CODE | CHECK DATE (VOID AFTER 90 DAYS) | CHECK NUMBER | CHECK AMOUNT
12/12/2008 | 5286501 | $**********1.00

ONE DOLLAR AND NO CENTS

PAYABLE AT PAR
WACHOVIA BANK OF SOUTH CAROLINA, N.A.
COLUMBIA, S.C.

Emma Johnson

⑈5286501⑈ ⑆053200019⑆ 2079900430615⑈

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$1.00
CERTIFIED AMT	MEDICAID TOTAL
$0.00	$1.00
	CHECK TOTAL

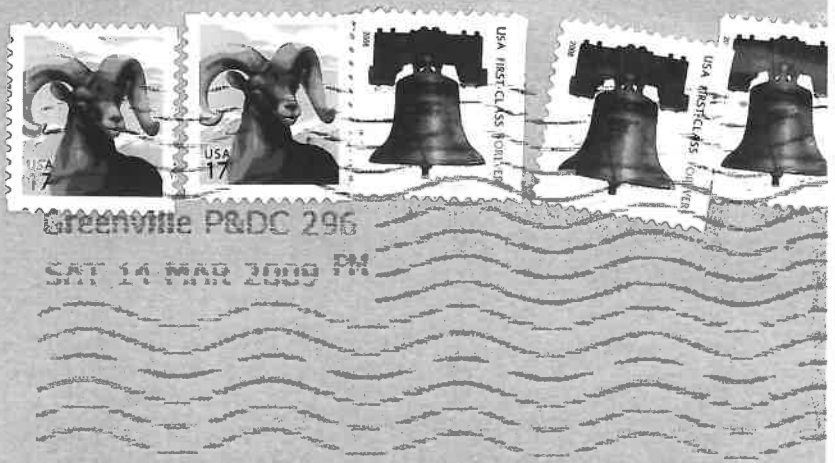
STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

5286501
CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307

ANIEL
375 [illegible]
SPARTANBURG SC 29307



EMMA FORKNER, DIRECTOR
S.C. Department of Health & Human Services
P.O. Box 8206
Columbia S.C.
29202-8206

From: Daisy G. Massey
To: Brenda James; Margarete Keller
Date: 3/20/2009 11:30 am
Subject: Log 000505

Kevin told me that Log 000505 should have gone to BZ--Health Services and that he gave the original back to Felicity. I don't know if she has asked for it to be relogged yet but just wanted to let you know that we don't have it anymore --especially since it has a short turnaround date. Thanks.

Daisy G. Massey
Administrative Assistant
Bureau of Medicaid Systems Mgmt.
SC DHHS
1801 Main St., Columbia, SC 29201
Tel# (803) 898-2894 Fax: (803) 255-8213
e-mail: masseydg@scdhhs.gov

Log #505

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

April 2, 2009

Emma Forkner
Director

Daniel L. Moore, M.D.
Living With ADD
2375 East Main Street, Suite A-311
Spartanburg, South Carolina 29307

Dear Dr. Moore:

Thank you for your letter regarding claims that were processed with the incorrect payment. We welcome the opportunity to be of assistance.

On March 27, 2009, Maureen Ryan, Program Representative for Physicians Services, spoke with you and was able to begin resolving claims that were processed and paid incorrectly. Your program representative's primary responsibility is to assist with resolving claim edits, advise on policy issues, and provide educational opportunities. In addition to contacting Ms. Ryan when problems or issues arise, I also recommend you utilize our free online claims processing tool. The product, called the Web Tool, will allow you to submit, review, and correct claims at any time. The use of this tool would eliminate the issue of inaccurate placement of data on the claim form or the misinterpretation of paper submission. You can sign up for Web Tool by calling (888) 289-0709.

We appreciate you taking the time to contact us, and for your continued support and participation in the South Carolina Medicaid program. If you have any additional questions or need any further assistance, please do not hesitate to contact Ms. Erica Dimes, Team Leader, at (803) 898-2660.

Sincerely,

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

MG/wds

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