

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>3-16-09</i>
--------------------	------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>100505</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>3-25-09</i> DATE DUE _____ <input type="checkbox"/> Necessary Action		

*cc: Ms. Fortner
e-mail from Daisy attached
Cleared 4/21/09, letter
attached.*

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

RECEIVED

MAR 16 2009

Department of Health & Human Services
OFFICE OF THE DIRECTOR

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, DOB 10/31/96, 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: 864-579-1398

dlmsm@bellsouth.net

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

PICA

PICA

1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>	(Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) <input type="checkbox"/>	1A. INSURED'S I.D. NUMBER	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MORAN, ALAN		3. PATIENT'S BIRTH DATE MM DD YY 07/09/45	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 11009		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURER CITY STATE ZIP CODE
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S NAME (Last Name, First Name, Middle Initial) MORAN, ALAN
9. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE 10-27-09
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	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 _____ DATE 10-27-09
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE <input type="checkbox"/> YES <input type="checkbox"/> NO	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

This is a "copy" of the original claim dated 10/27/09 in amount of \$90.00
Dayana Chg.
(Indicate the date and amount)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE 10-27-09	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. NPI 17B. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	22. MEDICAID RESUBMISSION 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 EMG CPT/HCPCS	C. PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	E. DIAGNOSIS DIAGNOSIS POINTER	F. CHARGES G. DTS OR UNITS H. FERT ID. QUAL.	I. RENDERING PROVIDER ID. #
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 314.9 3. 280.0	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB?	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER	24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. CHARGES	G. DTS OR UNITS	H. FERT ID. QUAL.
25. FEDERAL TAX I.D. NUMBER	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? For cash, claimant sees back	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE	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 _____ DATE 10/28/09	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (864) 579-3900	34. BILLING PROVIDER INFO & PH # (864) 579-3900	35. BILLING PROVIDER INFO & PH # (864) 579-3900	36. BILLING PROVIDER INFO & PH # (864) 579-3900	37. BILLING PROVIDER INFO & PH # (864) 579-3900	38. BILLING PROVIDER INFO & PH # (864) 579-3900

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

PROVIDER ID. 000021103
DEPT OF HEALTH AND HUMAN SERVICES
080646
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE
11/09/2007

PAGE
1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED DATE(S) MDDYY	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID 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	01/26/09	00.00	0.00 R	7420547401	K R LANDRUM	0000	L01*692 L02 989	0.00	0.00
LONGMA	07299006940		00.00	73.00 P	9718623901	M A LONG	0000	L01*692	2.00	0.00
BREWINGTO	072990069500		00.00	75.00 P	0780417930	H C BREWINGTON	0000	L01*692	0.00	0.00
SEAGLEJ	0729900696001400		00.00	0.00 R	7470340202	J C SEAGLE	0000	L00*943	0.00	0.00
OBRIENBRA	0729900697001400A	102507 99215	100.00	94.00 P	4718277001	B W OBRIEN	0000	L01*692	2.00	0.00
MULLINANE	0729900698001400A	092607 99245	450.00	178.42 P	5780753277	E MULLINAX	0000	L01*692	0.00	0.00
MOSHER	0730210870021200A	062807 99214 102507 99214	130.00 65.00	130.00 P 65.00 P	5471223203	J M CANNON	0000	L01*692	0.00	0.00
MOSHER	0730210871021200A	102507 99215	0.90 0.90	0.90 P 0.90 P	9730931301	H M CANNON	0000	L01*692	0.00	0.00

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



Please see accompanying Full Prescribing Information including hand

INCOLLECT

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

MEDICAID PG TOT

CERTIFIED AMT

MEDICAID TOTAL

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
12375 EAST MAIN ST # A-311
SPARTANBURG SC 29307

1

	PICA
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PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PROVIDER ID. 000165122
 DEPT OF HEALTH AND HUMAN SERVICES
 080646
 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 T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED D CHARGES	COPAY AMT	TITLE 18 PAYMENT
FARRB	0802308136016900A 01		092507	99245	450.00 450.00	0.00 0.00	R 2424546704	B FARR	000	L01*692	0.00	0.00
								EDITS: L00*943 EDITS: L01 852 11/09/07				
MOSHERH	0802308137016900A 01		102507	99215	90.00 90.00	0.00 0.00	R 9730931301	H M CANNON	000	L01*692	0.00	0.00
								EDITS: L00*943 EDITS: L01 852 11/09/07				
	TOTALS		2		540.00	0.00					0.00	0.00

Already Paid - 

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
 \$0.00
 CERTIFIED AMT

MEDICAID PG TOT
 \$0.00
 MEDICAID TOTAL

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

PICA

1. MEDICARE ☒ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP ☐ FECA ☐ OTHER ☐
(Medicare #) (Medicaid #) (Medicare #) (SSN) (Member ID#) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cannon Gary 3. PATIENT'S BIRTH DATE 07/24/95 SEX M

5. PATIENT'S ADDRESS (No., Street) 1025 09 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

CITY 1025 09 STATE 1025 09

ZIP CODE 1025 09 TELEPHONE (include Area Code) 1025 09

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 1025 09 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. OTHER INSURED'S POLICY OR GROUP NUMBER 1025 09 b. AUTO ACCIDENT? YES ☐ NO ☐

b. OTHER INSURED'S DATE OF BIRTH 1025 09 SEX 1025 09 PLACE (State) 1025 09

c. EMPLOYER'S NAME OR SCHOOL NAME 1025 09 c. OTHER ACCIDENT? YES ☐ NO ☐

d. INSURANCE PLAN NAME OR PROGRAM NAME 1025 09 10d. RESERVED FOR LOCAL USE

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 1025 09 DATE 1025 09

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 1025 09 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 1025 09 17a. NPI 1025 09

18. RESERVED FOR LOCAL USE 1025 09

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1025 09

1. 1025 09 3. 1025 09

2. 1025 09 4. 1025 09

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. CPT/HCPCS D. EXPLAIN UNUSUAL CIRCUMSTANCES E. DIAGNOSIS POINTER

MM DD YY MM DD YY MM DD YY MM DD YY MM DD YY

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1025 09 1025 09 1025 09 1025 09 1025 09

1025 09 1025 09 1025 09 1025 09 1025 09

1025 09 1025 09 1025 09 1025 09 1025 09

25. FEDERAL TAX I.D. NUMBER 1025 09 SSN EIN 1025 09

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.) 1025 09

SIGNED 1025 09 DATE 1025 09

NUCC Instruction Manual available at: www.nucc.org

1a. INSURED'S ID. NUMBER 1025 09 (For Program in Item 1)

4. INSURED'S NAME (Last Name, First Name, Middle Initial) 1025 09

7. INSURED'S ADDRESS (No., Street) 1025 09

CITY 1025 09 STATE 1025 09

ZIP CODE 1025 09 TELEPHONE (include Area Code) 1025 09

11. INSURED'S POLICY GROUP OR FECA NUMBER 1025 09

a. INSURED'S DATE OF BIRTH 1025 09 SEX 1025 09

b. EMPLOYER'S NAME OR SCHOOL NAME 1025 09

c. INSURANCE PLAN NAME OR PROGRAM NAME 1025 09

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐

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 1025 09

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

20. OUTSIDE LAB? YES ☐ NO ☐

22. MEDICAID RESUBMISSION ORIGINAL REF. NO. 1025 09

23. PRIOR AUTHORIZATION NUMBER 1025 09

F. CHARGES G. DAYS UNITS H. ICD-9-CM QUAL. J. RENDERING PROVIDER ID. #

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28. TOTAL CHARGE 1025 09 29. AMOUNT PAID 1025 09 30. BALANCE DUE 1025 09

33. BILLING PROVIDER INFO & PH # 1025 09

SIGNED 1025 09 DATE 1025 09

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

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

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

DOC IND Y

CLAIM CONTROL #0808505124011800A

PAGE 18809 ECF 18809 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

CLAIM EDITS

943

LINE EDITS

01) 234

02) 234 852

** AGENCY USE ONLY **

** APPROVED EDITS **

** REJECTED LINE EDITS **

TAXONOMY:

SFL ZIP:

PRV ZIP: 29307

1 PROVIDER

2 RECIPIENT

3 P AUTH

4 TPL

5 INJURY

6 EMERG

7 PC COORD

8 ----

9 DIAGNOSIS ----

ID

ID

NUMBER

CODE

EMERG

PC COORD

PRIMARY

SECONDARY

080646

9730931301

NUMBER

CODE

EMERG

PC COORD

PRIMARY

SECONDARY

NPI:

9730931301

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SECONDARY

NPI:

9730931301

NUMBER

CODE

EMERG

PC COORD

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

TPICA

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <i>Mathie Halay</i>		3. PATIENT'S BIRTH DATE MM DD YY <i>01/09/95</i>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <i>Mathie Halay</i>	
5. PATIENT'S ADDRESS (No. Street) <i>1008 08</i>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) <i>1008 08</i>		8. INSURED'S POLICY GROUP OR FECA NUMBER <i>1008 08</i>	
CITY		STATE		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		12. INSURED'S DATE OF BIRTH	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)		b. EMPLOYER'S NAME OR SCHOOL NAME		c. EMPLOYER'S NAME OR SCHOOL NAME	
b. OTHER INSURED'S DATE OF BIRTH		b. AUTO ACCIDENT?		c. OTHER ACCIDENT?		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT?		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		e. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)		14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	

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

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 _____ DATE *10-25-07*

SIGNED *Signature of the file* DATE *10-25-07*

14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

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

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

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

17. OUTSIDE LAB?

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. MEDICAID RESUBMISSION

18. MEDICAID RESUBMISSION

19. RESERVED FOR LOCAL USE

19. RESERVED FOR LOCAL USE

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to process this claim)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to process this claim)

21. DATE(S) OF SERVICE

21. DATE(S) OF SERVICE

22. FEDERAL TAX I.D. NUMBER

22. FEDERAL TAX I.D. NUMBER

23. PATIENT'S ACCOUNT NO.

23. PATIENT'S ACCOUNT NO.

24. ACCEPT ASSIGNMENT?

24. ACCEPT ASSIGNMENT?

25. SERVICE FACILITY LOCATION INFORMATION

25. SERVICE FACILITY LOCATION INFORMATION

26. SIGNATURE OF PHYSICIAN OR SUPPLIER

26. SIGNATURE OF PHYSICIAN OR SUPPLIER

27. CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF

27. CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF

28. TOTAL CHARGE

28. TOTAL CHARGE

29. AMOUNT PAID

29. AMOUNT PAID

30. BALANCE DUE

30. BALANCE DUE

31. BILLING PROVIDER INFO & PH #

31. BILLING PROVIDER INFO & PH #

32. ORIGINAL REF. NO.

32. ORIGINAL REF. NO.

33. AUTHORIZATION NUMBER

33. AUTHORIZATION NUMBER

34. DATE OF SERVICE

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35. RENDERING PROVIDER ID #

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139. RENDERING PROVIDER ID #

139. RENDERING PROVIDER ID #

RUN DATE 05/20/2008 000153233

REPORT NUMBER CLM3500

ANALYST ID PROV

SIGNON ID MARLR

TAXONOMY:

1 PROVIDER ID 080646
2 RECIPIENT ID 9730931301
NPI:

SFL ZIP:

3 P AUTH NUMBER
4 TPL
5 INJURY CODE

PRV ZIP: 29307

6 EMERG
7 PC COORD

8 ---- DIAGNOSIS ----
PRIMARY SECONDARY
314.9 300.3

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 22

DOC IND Y

CLAIM CONTROL #0802308137016900A

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

23 NDC

19 INDIVIDUAL PROVIDER

20 CHARGE IND

21 PAY

22 UNITS

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

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NPI: 1942303185

10/25/07
TAXONOMY: 2080P0006X

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

24 INS CARR NUMBER

25 POLICY NUMBER

26 INS CARR PAID

27 TOTAL CHARGE 90.00

28 AMT REC'D INS .00

29 BALANCE DUE 90.00

30 OWN REF # MOSHERH

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02

03

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 HABIL
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

REPORT NUMBER CLM3500

ANALYST ID PROD9

SIGNON ID ROGEK

TAXONOMY:

1 PROVIDER ID 080646
2 RECIPIENT ID 9730931301
3 SFL ZIP:
4 P AUTH NUMBER
5 TPL
6 INJURY CODE
7 PRV ZIP: 29307
8 PC COORD
9 DIAGNOSIS
PRIMARY 314.9
SECONDARY 300.3

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 22

DOC IND Y

CLAIM CONTROL #0808505124011800A

PAGE 8700 ECF 8700 PAGE 1 OF 1

EMC

ORIGINAL CGN:

ADJ CGN:

EDITS

INSURANCE EDITS

CLAIM EDITS

943 NPI # required

LINE EDITS

02) 852 duplicate pay

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

10	11	12	13	14	15	16	17	18	19	20	21	22
RES	ALLOWED	LN	DATE OF SERVICE	PLACE	PROC CODE	MOD	INDIVIDUAL PROVIDER	CHARGE IND	PAY	UNITS		
		1	02/08/08	11	99214	000	080646	65.00	1.000			
		2	10/25/07	11	99215	000	080646	90.00	1.000			
		3										
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24 INS CARR NUMBER
25 POLICY NUMBER
26 INS CARR PAID

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

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

PROVIDER ID.

000127455

PROFESSIONAL SERVICES

PAYMENT DATE

PAGE

080646

DEPT OF HEALTH AND HUMAN SERVICES

REMITTANCE ADVICE

05/30/2008

1

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
CANNONH	0808505124011800A 01 02		020808 102507	99214 99215	155.00 65.00 90.00	0.00 0.00 0.00	R 9730931301	H M CANNON	000 000		0.00 0.00	0.00 0.00
								EDITS: L00 943 EDITS: L02*692		L01*692 L02 852	11/09/07	
	TOTALS		1		155.00	0.00					0.00	0.00

\$0.00

STATUS CODES:

PROVIDER NAME AND ADDRESS

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

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

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

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

\$0.00

CERTIFIED AMT

MEDICAID TOTAL

\$0.00

\$0.00

\$0.00

CHECK TOTAL

CHECK NUMBER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (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)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <u>John Applebee</u>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) <u>John Applebee</u>
5. PATIENT'S ADDRESS (No., Street) <u>10100 Applebee</u>						7. INSURED'S ADDRESS (No., Street) <u>10100 Applebee</u>
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>				CITY
ZIP CODE	TELEPHONE (include Area Code) ()	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE authorize payment of medical benefits to the undersigned physician or supplier for services described below.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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.						14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT INJURY (first symptom) OR INJURY (accident) OR PREGNANCY(LMP)						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICARE RESUBMISSION ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER						24. A. DATE(S) OF SERVICE					
From		To		B. PLACE OF SERVICE		C. D. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS POINTER		F. \$ CHARGES	
MM	DD	YY	MM	DD	YY	EMG	EMG	EMG	EMG	EMG	EMG

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For paid claims use back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
<u>051000000</u>	<input type="checkbox"/>	<u>051000000</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<u>\$ 4500</u>	<u>\$</u>	<u>\$ 4500</u>
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)						
32. SERVICE FACILITY LOCATION INFORMATION						
33. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
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81. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
82. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
83. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
84. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
85. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
86. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
87. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
88. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
89. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
90. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
91. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
92. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
93. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
94. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
95. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
96. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
97. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
98. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
99. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						
100. BILLING PROVIDER INFO & PH # (PH#) 1-800-3960						

PHYSICIAN OR SUPPLIER INFORMATION

PROVIDER ID. 000021104
 DEPT OF HEALTH AND HUMAN SERVICES
 080646
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 11/09/2007

PAGE
 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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 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 2424546704 B	FARR EDITS: L00*943	000	L01*692	0.00	0.00
TOTALS					1054.90	560.32					0.00	0.00

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
 \$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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>	(Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)
---	---

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F
---	---	---

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
------------------------------------	---

CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
------	-------	--

ZIP CODE	TELEPHONE (Include Area Code) ()	Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>
----------	--------------------------------------	--

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) <input type="checkbox"/> YES <input type="checkbox"/> NO
---	--

b. OTHER INSURED'S DATE OF BIRTH MM <input type="checkbox"/> DD <input type="checkbox"/> YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
--	---	---

c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
-----------------------------------	--

d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
--	-----------------------------

12. PATIENTS 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

14. DATE OF CURRENT ILLNESS (First symptom), OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
--	---

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. <input type="checkbox"/> NPI
--	-----------------------------------

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO
----------------------------	--

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
--	---

23. PRIOR AUTHORIZATION NUMBER	24. A. DATE(S) OF SERVICE
--------------------------------	---------------------------

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. CHARGES	G. DAYS OR UNITS	H. ERSOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
---------------------------	---------------------	--------	--	----------------------	------------	------------------	----------------------	--------------	-----------------------------

25. FEDERAL TAX I.D. NUMBER	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For prior claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
-----------------------------	---------------------------	---	------------------	-----------------	-----------------

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
--	---	----------------------------------

34. SIGNATURE OF PHYSICIAN OR SUPPLIER	35. DATE
--	----------

36. SIGNATURE OF PHYSICIAN OR SUPPLIER	37. DATE
--	----------

38. SIGNATURE OF PHYSICIAN OR SUPPLIER	39. DATE
--	----------

40. SIGNATURE OF PHYSICIAN OR SUPPLIER	41. DATE
--	----------

42. SIGNATURE OF PHYSICIAN OR SUPPLIER	43. DATE
--	----------

44. SIGNATURE OF PHYSICIAN OR SUPPLIER	45. DATE
--	----------

46. SIGNATURE OF PHYSICIAN OR SUPPLIER	47. DATE
--	----------

48. SIGNATURE OF PHYSICIAN OR SUPPLIER	49. DATE
--	----------

50. SIGNATURE OF PHYSICIAN OR SUPPLIER	51. DATE
--	----------

PROVIDER ID. 000165122
 DEPT OF HEALTH AND HUMAN SERVICES
 080646
 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	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 - 

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	MEDICAID PG TOT
\$0.00	\$0.00
CERTIFIED AMT	MEDICAID TOTAL
\$0.00	\$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

REPORT NUMBER CLM3500

ANALYST ID PROV

SIGNON ID MARLR

TAXONOMY:

1 PROVIDER ID 080646
2 RECIPIENT ID 2424546704
NPI: 1942303185

SFL ZIP:

3 P AUTH NUMBER
4 TPL

5 INJURY CODE

PRV ZIP: 29307

6 EMERG
7 PC COORD

8 ---- DIAGNOSIS ----
9 PRIMARY SECONDARY
314.01 309.28

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 22

DOC IND Y

CLAIM CONTROL #0802308136016900A

PAGE 7532 ECF 7532 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 852 Duplicate Amt. - Wrong!

10 RECIPIENT NAME - BRANDON

FARR

11 DATE OF BIRTH 07/22/1994

12 SEX M

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROVIDER 20 CHARGE IND 21 PAY 22 UNITS

23
NDC

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

.00 1 09/25/07 11 99245 000 080646 450.00 1.000
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:

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

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 450.00
28 AMT REC'D INS .00
29 BALANCE DUE 450.00
30 OWN REF # FARRB

01

02

03

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 HABIL
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. 000076724
DEPT OF HEALTH AND HUMAN SERVICES
1942303185
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE
07/25/2008

PAGE
1

PROVIDER'S OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T ID. NUMBER	RECIPIENT NAME 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: L01 852 11/09/07			0.00	0.00
✓ SAWYER	0808502396005000A 01		020708	99215	85.00 85.00	85.00 85.00	P P	7716796601 C W SAWYER			0.00	0.00
✓ COOPER	0808502397005000A 01		030408	99215	75.00 75.00	73.00 73.00	P P	1882039402 D L COOPER			2.00	0.00
✓ SCHMIDT	0808502398005000A 01		030408	99215	100.00 100.00	98.72 98.72	P P	6421912502 A L SCHMIDT			0.00	0.00
BROWNLEE	0808502399005000A 01 02		080307 020808	99214 99214	130.00 65.00 65.00	0.00 0.00 0.00	R R R	7428785305 G L BROWNLEE			0.00 0.00 0.00	0.00 0.00 0.00
								EDITS: L01 953		L02 953		
✓ MASHER	0808502400005000A 01		020808	99214	65.00 65.00	65.00 65.00	P P	5471223203 J M CANNON			0.00	0.00
✓ BRANCH	0808502401005000A 01		012208	99215	100.00 100.00	98.72 98.72	P P	4630192284 N L BRANCH			0.00	0.00
✓ THREATT	0808502402005000A 01		020408	99215	100.00 100.00	98.72 98.72	P P	1641692701 G S THREATT			0.00	0.00
✓ LONG	0808502403005000A 01		021508	99215	75.00 75.00	73.00 73.00	P P	9718623901 M A LONG			2.00	0.00
✓ FOSTER	0808502404005000A 01		021908	99215	80.00 80.00	78.00 78.00	P P	6716614601 F L FOSTER			2.00	0.00
✓ SULLIVAN	0808502405005000A 01		022908	99215	100.00 100.00	96.72 96.72	P P	9723382101 C W SULLIVAN			2.00	0.00

\$766.88

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

STATUS CODES:

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

CHECK NUMBER

PROVIDER NAME AND ADDRESS

DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABIL
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 <input type="checkbox"/> MEDICARE # <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> MEDICAID # <input type="checkbox"/> (Medicaid #)	TRICARE <input type="checkbox"/> TRICARE # <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> CHAMPVA # <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK/LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER 2420406501	(For Program in Item 1)
--	---	--	---	--	--	--	---	-------------------------

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <u>Alvin J. Davis</u>	3. PATIENT'S BIRTH DATE MM DD YY <u>10/31/46</u>	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2420406501
5. PATIENT'S ADDRESS (No. Street) 	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No. Street) 	

CITY 	STATE 	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY 	STATE
ZIP CODE 	TELEPHONE (include Area Code) ()	Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>	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) <input type="checkbox"/> YES <input type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY 	b. EMPLOYER'S NAME OR SCHOOL NAME 	SEX <input type="checkbox"/> M <input type="checkbox"/> F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLACE (State) 	c. INSURANCE PLAN NAME OR PROGRAM NAME 	
c. EMPLOYER'S NAME OR SCHOOL NAME 	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME 	10d. RESERVED FOR LOCAL USE 	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.		

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 Alvin J. Davis DATE 10-3-08

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 	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 TO MM DD 	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD TO MM DD 	19. RESERVED FOR LOCAL USE 	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES
---	---	---	--	--	------------------------------------	---

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <u>314.1</u> 3. <u> </u>	22. MEDICAID RESUBMISSION CODE 	23. PRIOR AUTHORIZATION NUMBER 	24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG CPT/HPCS MODIFIER	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	D. DIAGNOSIS POINTNER	E. F. \$ CHARGES	G. DTS FROM PAY ID. QUAL.	H. I. RENDERING PROVIDER ID. #
--	--	--	---	--	---	--------------------------	------------------	---------------------------	--------------------------------

25. FEDERAL TAX I.D. NUMBER <u>590084cc8</u>	SSN EIN <input checked="" type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <u>St. Albans</u>	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ <u>4500</u>	29. AMOUNT PAID \$ <u> </u>	30. BALANCE DUE \$ <u>4500</u>
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.) <u>Alvin J. Davis MD</u>	32. SERVICE FACILITY LOCATION INFORMATION 	33. BILLING PROVIDER INFO & PH # <u>Alvin J. Davis MD</u> <u>590084cc8</u>				

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

PROVIDER ID.

080646

000021104
DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES

REMITTANCE ADVICE

PAYMENT DATE

11/09/2007

PAGE

2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M 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 P 4.50 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 P 4.50 P	2424546704	B FARR EDITS: L00*943	000	L01*692	0.00	0.00
TOTALS			10		1054.90	560.32					0.00	0.00

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

\$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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>	<input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY <input type="checkbox"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>
ZIP CODE	TELEPHONE (include Area Code) ()	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	12. INSURED'S DATE OF BIRTH <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY <input type="checkbox"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY <input type="checkbox"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	c. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	d. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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 <u>Signature of Dr. [illegible]</u> DATE <u>11/18/08</u>		
14. DATE OF CURRENT <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP)		
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		
17a. <input type="checkbox"/> NPI		
17b. <input type="checkbox"/> NPI		
19. RESERVED FOR LOCAL USE		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <u>314.01</u> 3. <u> </u>		
2. <u>313.81</u> 4. <u> </u>		
24. A. DATE(S) OF SERVICE <input type="checkbox"/> B. PLACE OF SERVICE <input type="checkbox"/> C. PROCEDURE(S), SERVICE(S), OR SUPPLIES <input type="checkbox"/> D. EMG CPT/HCPCS <input type="checkbox"/> E. DIAGNOSIS POINTER		
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/> 26. PATIENT'S ACCOUNT NO. <input type="checkbox"/> 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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.)		
32. SERVICE FACILITY LOCATION INFORMATION		
33. BILLING PROVIDER INFO & PH # <input type="checkbox"/> (861) 599-3960		
34. TOTAL CHARGE <input type="checkbox"/> 100 - 29. AMOUNT PAID <input type="checkbox"/> 100 - 30. BALANCE DUE <input type="checkbox"/> 0		
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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 Fowler
Dept. of HHS
PO Box 8206
Columbia SC
29202-8206

Dear Mrs Fowler,

I am returning this check to you along with a copy of the original claim form so that you make the appropriate corrections and resubmit a check in the appropriate amount. Thank you for prompt resolution of this situation.

Sincerely,

Daniel L. Moore, MD

PROVIDER ID. 000034834
 DEPT OF HEALTH AND HUMAN SERVICES
 1942303185
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 12/12/2008

PAGE
 1

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

CHECK DATE	CHECK NUMBER	CHECK AMOUNT
VOID AFTER 90 DAYS		
12/12/2008	5286501	\$*****1.00

ONE DOLLAR AND NO CENTS
 WACHOVIA BANK OF SOUTH CAROLINA, N.A.
 COLUMBIA, S.C.

Emma J. Moore

⑈5286501⑈ ⑆05320001912079900430615⑈

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.

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

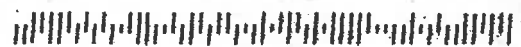
STATUS CODES:

P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 E = ENCOUNTER
 5286501
 CHECK NUMBER

PROVIDER NAME AND ADDRESS

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

ANIEL



375

SPARTANBURG SC 29307



Greenville P&DC 296

SAT 14 MAR 2009 PM

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



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,

A handwritten signature in cursive script, appearing to read "Bz Giese".

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

MG/wds

Log # 505