DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	7-17-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 12-020	[X] Prepare reply for the Director's signature DATE DUE 7-25-12
2. DATE SIGNED BY DIRECTOR cc: McKeck, Singleton, Kost Closed 7/19/12, see e-mail response.	[ ] Prepare reply for appropriate signature DATE DUE [ ] 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.			

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:
ARMED SERVICES
RANKING, PERSONNEL SUBCOMMITTEE
FOREIGN AFFAIRS
EDUCATION AND LABOR
HOUSE POLICY

Congress of the United States
House of Representatives

COUNTIES:
AIKEN*
ALLENDALE
BARNWELL
BEAUFORT
CALHOUN*
HAMPTON
JASPER
LEXINGTON
ORANGEBURG*
RICHLAND*
(*PARTS OF)

W. ERIC DELL
CHIEF OF STAFF
AND COUNSEL

July 11, 2012

The Honorable Anthony Keck
Director, S. C. Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

RE: Trey Martin and Ann-Marie Beason; 656 Cedar Road; Aiken, SC 29803

Dear Director Keck,

I am writing to you on behalf of the above named constituents who have contacted me regarding an issue involving the Mother's Medicare Reimbursement Claims. Enclosed is correspondence from the constituents further explaining their concerns. Your kind attention in this matter would be greatly appreciated.

It is an honor to represent the people of the Second Congressional District, and I value your input. Thank you for your time and concern in this and all other matters.

Please respond to the Aiken District Office at 1555 Richland Ave E, Suite 700, Aiken, South Carolina 29801. The phone number is 803-608-9747. The e-mail address is Ted.Felder@mail.house.gov.

Very truly yours,

Joe Wilson

JOE WILSON
Member of Congress

JW/TF

MIDLANDS OFFICE:
1700 SUNSET BLVD. (US 378), SUITE 1
WEST COLUMBIA, SC 29169
(803) 939-0041
FAX: (803) 939-0078

212 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4002
(202) 225-2452
FAX: (202) 225-2455
www.joewilson.house.gov

LOWCOUNTRY OFFICE:
903 PORT REPUBLIC STREET
P.O. BOX 1538
BEAUFORT, SC 29901
(843) 521-2530
FAX: (843) 521-2535

TOLL FREE 1-888-381-1442

July 10, 2012

Congressman Joe Wilson
Second District of South Carolina

Congressman Wilson,

My name is Trey Martin of Aiken, SC. I am currently the sole caretaker of my mother, Ann-Marie Beason. She is on disability with no other form of income except what I can afford to give her after my bills. Back in February 2012 I had to purchase a new pump for the mattress of her hospital bed at a cost of $450 out of pocket. I work and have been at my current job for seven years with my own health concerns starting to show their ugly head; it is difficult physically and financially.

I sent in a claim for reimbursement to Medicare. Before sending I called to make sure that I had everything in line and everything completed; I know that Medicare can be difficult to work with. After sending in all of the appropriate paperwork I received a letter of denial 60 days later. I called again and with the help of a very friendly and helpful agent (not the norm) I worked through all of the things that caused the denial and then resubmitted the paperwork on May 1, 2012. Again to wait another 60 days. I called again yesterday to check on the status only to find out that they did not have any of the paperwork from the resubmission on file.

I recently found an oral surgeon to pull her teeth that the bone disease had ruined. I've been saving for over a year so that I could afford dentures in hopes that maybe I can improve her quality of life and make the next 12-18 months of her life left as easy as possible. Most recently our air conditioner at the house went out and I've had to purchase a large window unit, taking over 50% of what I had set aside for her teeth. This refund would greatly help cover the costs of the dentures which sadly I will not be able to be reimbursed for since Medicare does not cover them.

I honestly am tired of having to fight. I am at my wits end. Is there any help that you or your office can offer? It would be greatly appreciated.

Sincerely,

Trey Martin
656 Cedar Rd
Aiken, SC 29803

803-645-8704 treymartin82@gmail.com

-d fielder@mail.house.gov
1555 Richland Ave. E
Suite 700
Aiken 29801
(803) 608-9747

CONGRESSMAN JOE WILSON

Second District of South Carolina

Privacy Release

Consent for Release of Personal Records by Executive Agencies

To Whom It May Concern:

I have sought assistance from the Office of Congressman Joe Wilson on a matter that may require the release of information maintained by your agency, and which may be prohibited from dissemination under the Privacy Act of 1974. I hereby authorize you to release all relevant portions of my records or to discuss information involved in this case with Congressman Wilson or any authorized member of his staff until the matter is resolved.

Name of Agency: Medicare

× Ann-Marie Beason
Name (please print)

× Oct. 19, 1962
Date of Birth

× 6556 Cedar Rd. Aiken, SC 29803
Address

City

P.O. Box 3691 Aiken, SC 29802
Zip

× 249-29-6851
Social Security Number

E-mail Address

Telephone Number - Home

Trey Martin son 803-645-8704
Telephone Number – Cell

× [signature]
Signature

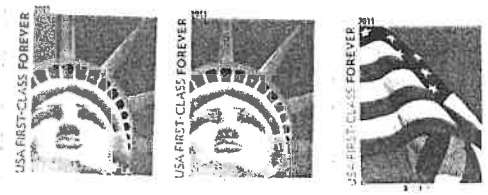
× 7-10-12
Today's Date

Please briefly explain your concern (use the back if necessary):

Congressman Joe Wilson (SC-02)
1700 Sunset Boulevard, Suite 1 | West Columbia, SC 29169
Phone: (803) 939-0041 | Fax: (803) 939-0078

Sent
the
second
time

Ann-Marie Beason
P.O. Box 3691
Aiken, SC
29802



CGS – DME MAC Jurisdiction C
Attn: Redetermination Dept.
P.O. Box 20009
Nashville, TN
37202

Appeals Information - Part B

If you disagree with any claims decisions on this notice, your appeal must be received by **July 3, 2012.** Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the following address: CGS - DME MAC Jurisdiction C, Attn: Redetermination Dept, P. O. Box 20009, Nashville, TN 37202.

(You may also send any additional information you may have about your appeal.)

3) Sign here Ann Marie Beason Phone number (803) 292-1975

4) Medicare Number 249-29-6851A

Dated: April 30, 2012

Place of purchase, Sport Aid, does NOT file with Medicade.

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)

Beason, Ann Marie

2 Claim Number from Health Insurance Card

214|21|9|6|8|5|1|A

Patient's Sex
☐ Male
☒ Female

3 Patient's Mailing Address (City, State, Zip Code)

Check here if this is a new address ☐

P.O. Box 3691
(Street or P.O. Box – Include Apartment Number)

Aiken SC 29802
(City) (State) (Zip)

3b Telephone Number (Include Area Code)

(803) 292-1975

4 Describe the illness or injury for which patient received treatment

Purchase Date: Feb. 6, 2012
Purchased From: SportAid 78 Bay Creek Rd.
Loganville, GA 30052
1-770-554-5033
Illness: Degenerative Disk Disease, Osteopenia, Scoliosis
Cost: $460.00

4b Condition was related to:
A. Patient's employment ☐ Yes ☒ No
B. Accident ☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☒ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☒ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☒ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:

Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

Ann Marie Beason

6b Date signed

2-18-12

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Sales Order

SPORTAID/MEDAID/DIV SRG INC
78 Bay Creek Rd.
Loganville, GA. 30052
Sportaid.com / MedaidMedical.com
staff@sportaid.com fax(770)554-5944
7705545033

Order Number: 0152790
Order Date: 2/1/2012

Salesperson: KS
Customer Number: MATRE

Sold To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803
Confirm To:

Ship To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803

Customer P.O.	Ship VIA	F.O.B.	Terms
	GROUND		PREPAID

Item Code	Unit	Ordered	Shipped	Back Order	Price	Amount
SP-5800	EACH	1.00	0.00	0.00	450.0000	450.00
APM 2 PUMP DELUXE CONTROL UNIT			Whse: 000			

PER PHONE ORDER THANK YOU, KIM
PER CUST GAVE PART #
RAN THRU CR'S ENDING IN #8387 IN THE AMOUNT OF $460.0

Coding # E1399
Ref. # E0277 APM Mattress

Motor is for pump that circulates air through mattress.

Net Order:	450.00
Less Discount:	0.00
Freight:	10.00
Sales Tax:	0.00
Order Total:	460.00

SEE BACK OF DOCUMENT FOR LISTING OF SECURITY FEATURES

John Downey, DO/Melanie Bowen, PA-C- Royal Pain Center

2922 Professional Parkway, Suite A,
Augusta, GA 30907
(706)855-2767
LIC #004613
DEA # FD 0323927 / MB1584134

Name ANNMARIE BEASON DOB 10/19/1962 Date 1/2/2012

Address PO BOX 3691, Aiken, SC 29802

Misc. 1

New Motor for patients hospital bed. Dx: 724.2/724.5/729.5

Dispense: 1
Refill:0

Melanie Bowen PA-C

PA-C PA-C

Dispense as Written May Substitute

This patient has signed an agreement indicating that all of his/her pain medications are to be prescribed from this office.
This prescription is VOID if more than one medication is listed above.
Please contact my office if you have reason to believe that this prescription has been altered.

This is from the doctor. This was previously included.

Pump is for mattress that circulates air through mattress.

SEE BACK OF DOCUMENT FOR LISTING OF SECURITY FEATURES

Invoice

Page:

SPORTAID/MEDAID/DIV SRG INC
78 Bay Creek Rd.
Loganville, GA. 30052
Sportaid.com / MedaidMedical.com
staff@sportaid.com fax(770)554-5944
(770) 554-5033

Invoice Number: 0203126-IN
Invoice Date: 2/9/2012

Order Number: 0152790
Ship Date: 2/6/2012
Salesperson: KS
Customer Number: MATRE

Sold To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803 UNITED STATES

Ship To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803 UNITED STATES

Confirm To:

Customer P.O.	Ship VIA	F.O.B.	Terms
	GROUND		PREPAID

Item Number	Loc	Unit	Ordered	Shipped	Back Ordered	Price	Amount
iP-5800		EACH	1.00	1.00	0.00	450.0000	450.00
APM 2 PUMP DELUXE CONTROL UNIT							

PER PHONE ORDER THANK YOU, KIM
PER CUST GAVE PART #
RAN THRU CR'S ENDING IN #8387 IN THE AMOUNT OF $460.0

Coding # E1399
@ ref. # E0277 APM Mattress
Motor is for
Pump that circulates air
through mattress.

Notice: Call 770-554-5033 for a Return Authorization number before returning any item purchased from SRG Inc. | Sportaid | Medaid.

Net Invoice:	450.00
Less Discount:	0.00
Freight:	10.00
Sales Tax:	0.00
Invoice Total:	460.00

Use the following address table to ensure the correct address will be provided on the claim.

If you live in:	Return your form to:
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	NHIC, Corp. P.O. Box 9165 Hingham, MA 02043-9165
Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	National Government Services, Inc. DMEPOS Operations Medicare DMEPOS Claims P.O. Box 7027 Indianapolis, IN 46207-7027
Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia	CIGNA Government Services P.O. Box 20010 Nashville, TN 37202-0010
Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian Administrative Services P.O. Box 6727 Fargo, ND 58108-6727

Sent
first
time

Rcvd 4-30-2012

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

THIS IS A COPY OF THE STATEMENT YOU REQUESTED

February 29, 2012

ANNMARIE BEASON
PO BOX 3691
AIKEN SC 29802-3691

JC

151081 000052 0001 of 0002

BE INFORMED: Beware of telemarketers or advertisements offering free or discounted Medicare items and services.

CUSTOMER SERVICE INFORMATION

Your Medicare Number: XXX-XX-6851A

If you have questions, call:
Call: 1-800-MEDICARE
(1-800-633-4227) (18003)
Ask for Medical Supplies

TTY (tele-typewriter) and TDD users only should call: 1-877-486-2048

This is a summary of claims processed from 12/01/2011 through 02/29/2012.

PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim number 12054150001000						
SUPPLIER UNKNOWN, PO BOX 20010, NASHVILLE, TN 37202-0010						a,b,c
02/06/12	1.0 Durable medical equipment mi (E1399)	$450.00	$0.00	$0.00	$0.00	d,e

Notes Section:

a The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered.

b Medicare will process your first claim only. In the future, you must use a Medicare enrolled supplier and provide the supplier identification number on your claim. For a listing of enrolled Medicare suppliers, contact your local Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

c Your provider must complete and submit your claim.

d This item or service was denied because information required to make payment was missing.

e You do not have to pay this amount.

Deductible Information:

You have met the Part B deductible for 2012.

THIS IS NOT A BILL - Keep this notice for your records.

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)

Beason, Ann Marie

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

2 Claim Number from Health Insurance Card

214|21|9|6|8|5|1|A

Patient's Sex
☐ Male
☒ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐

P.O. Box 3691
(Street or P.O. Box – Include Apartment Number)

Aiken SC 29802
(City) (State) (Zip)

3b Telephone Number (Include Area Code)

(803) 292-1975

4 Describe the illness or injury for which patient received treatment

Purchase Date: Feb. 6, 2012
Purchased From: SportAid 78 Bay Creek Rd.
Loganville, GA 30052
1-770-554-5033
Illness: Degenerative Disk Disease, Osteopenia, Scoliosis
Cost: $460.00

4b Condition was related to:
A. Patient's employment
☐ Yes ☒ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☒ No

5 a. Are you employed and covered under an employee health plan?
☐ Yes ☒ No

b. Is your spouse employed and are you covered under your spouse's employee health plan?
☐ Yes ☒ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:

Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

2-18-12

IMPORTANT
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Invoice

SPORTAID/MEDAID/DIV SRG INC
78 Bay Creek Rd.
Loganville, GA. 30052
Sportaid.com / MedaidMedical.com
staff@sportaid.com fax(770)554-5944
(770) 554-5033

Invoice Number: 0203126-IN
Invoice Date: 2/9/2012

Order Number: 0152790
Ship Date: 2/6/2012
Salesperson: KS
Customer Number: MATRE

Sold To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803 UNITED STATES

Confirm To:

Ship To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803 UNITED STATES

Customer P.O.	Ship VIA	F.O.B.	Terms
	GROUND		PREPAID

Item Number	Loc	Unit	Ordered	Shipped	Back Ordered	Price	Amount
SP-5800		EACH	1.00	1.00	0.00	450.0000	450.00
APM 2 PUMP DELUXE CONTROL UNIT							

PER PHONE ORDER THANK YOU, KIM
PER CUST GAVE PART #
RAN THRU CR'S ENDING IN #8387 IN THE AMOUNT OF $460.0

Notice: Call 770-554-5033 for a Return Authorization number before returning any item purchased from SRG Inc. | Sportaid | Medaid.

Net Invoice:	450.00
Less Discount:	0.00
Freight:	10.00
Sales Tax:	0.00
Invoice Total:	460.00

Sales Order

SPORTAID/MEDAID/DIV SRG INC
78 Bay Creek Rd.
Loganville, GA. 30052
Sportaid.com / MedaidMedical.com
staff@sportaid.com fax(770)554-5944
7705545033

Order Number: 0152790
Order Date: 2/1/2012

Salesperson: KS
Customer Number: MATRE

Sold To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803
Confirm To:

Ship To:
TREY MARTIN
656 CEDAR ROAD
AIKEN, SC 29803

Customer P.O.	Ship VIA	F.O.B.	Terms
	GROUND		PREPAID

Item Code	Unit	Ordered	Shipped	Back Order	Price	Amount
SP-5800	EACH	1.00	0.00	0.00	450.0000	450.00
APM 2 PUMP DELUXE CONTROL UNIT			Whse: 000			

PER PHONE ORDER THANK YOU, KIM
PER CUST GAVE PART #
RAN THRU CR'S ENDING IN #8387 IN THE AMOUNT OF $460.0

Net Order:	450.00
Less Discount:	0.00
Freight:	10.00
Sales Tax:	0.00
Order Total:	460.00

Span-America Medical Systems
70 Commerce Center
Greenville SC 29615

Packing Slip

Bill of Lading Num.	M069335
Document Date	2/2/2012
Page	1
Who Printed	shipping02
Date/Time Printed	2/3/2012 1:31:21 PM

INSTRUCTIONS:
PREPAID/ADD FREIGHT

Ship To: *** REPRINT ***

TREY MARTIN
656 CEDAR ROAD
803-641-0501
AIKEN SC 29803

0

Sold To:

SPORTAID/MEDAID

* Item Shipped Directly from Vendor

Purchase Order No.	Customer ID	Salesperson ID	Trailer No.	Payment Terms	Master No.
0062104	05392	2008	808342	NET 30	360,606

Quantity	Shipped	Remain	Req. Ship	Item Number	Description	Ship Wt.	Site	Ship Date	UOM
					Shipping Method				
1	1		2/3/2012	5800	PG APM2 DELUXE PUMP	8.00	FG1	2/3/2012	EA

Loose Pieces: 1
Pieces / Skids:

Trailer # _____
Carrier _____

Freight Charges
Check box if charges are to be collect

Total Wt. 8.00

Driver Signature/Date
Carrier acknowledges receipt of goods

Received subject to the classifications and tariffs in effect on the date of issue of this Bill of Lading, the property described above in apparent good order, except as noted (contents and conditions of contents of package unknown) consigned, and destined as indicated above which said carrier (the wordarrier being understood throughout this contra as meaning any person or corporation in possession of the property undethe contract agrees to carry to its usual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. It is mutually agreed as to each carrier of all or any of said property over all or any portion of said route to destinatio and as to each party at anytime interested in all or any said propertythat every service to be performed hereunde

SEE BACK OF DOCUMENT FOR LISTING OF SECURITY FEATURES

John Downey, DO/Melanie Bowen, PA-C- Royal Pain Center

2922 Professional Parkway, Suite A,
Augusta, GA 30907
(706)855-2767
LIC #004613
DEA # FD 0323927 / MB1584134

Name ANNMARIE BEASON DOB 10/19/1962 Date 1/2/2012

Address PO BOX 3691, Aiken, SC 29802

Misc. 1

New Motor for patients hospital bed. Dx: 724.2/724.5/729.5

Dispense: 1
Refill:0

Melanie Bowen PA-C

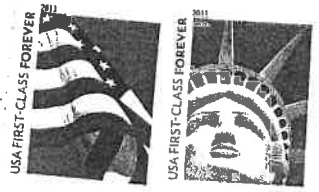
_____ PA-C
Dispense as Written

_____ PA-C
May Substitute

This patient has signed an agreement indicating that all of his/her pain medications are to be prescribed from this office.
This prescription is VOID if more than one medication is listed above.
Please contact my office if you have reason to believe that this prescription has been altered.

SEE BACK OF DOCUMENT FOR LISTING OF SECURITY FEATURES

Ann-Marie Beason
P.O. Box 3691
Aiken, SC 29802



CIGNA Government Services
P.O. Box 20010
Nashville, TN
37202-0010

Brenda James

Log #20

From: Teeshla Curtis
Sent: Wednesday, August 01, 2012 9:36 AM
To: Brenda James
Cc: Jennifer Lynch
Subject: FW: Log 0020 Email Closure
Attachments: Cong. Wilson - Ann Marie Beason.pdf

This log was also closed July 19th with an email to Congressman Wilson's office explaining that the issue was related to Medicare not Medicaid. Jenny also forwarded the original letter to the Office on Aging.

Teeshla

From: Jennifer Lynch
Sent: Wednesday, August 01, 2012 9:20 AM
To: Teeshla Curtis
Subject: FW: Log 0020 Email Closure

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:31 AM
To: Brenda James
Subject: Log 0020 Email Closure

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:30 AM
To: 'ted.felder@mail.house.gov'
Cc: 'mcdong@aging.sc.gov'
Subject: Congressman Wilson Constituent Letter - Ann-Marie Beason

Mr. Felder,

The attached letter that was referred to our office is regarding a Medicare issue rather than Medicaid. Since this department does not handle Medicare billing, I am copying Gloria McDonald on this email to determine if the Office on Aging can assist with this matter. Gloria: Please research and respond back to Mr. Felder regarding this matter.

Thanks,

Jenny Lynch
Legislative Affairs
SC Department of Health and Human Services
Office: (803) 898-3965
Cell: (803) 351-5673
Fax: (803) 255-8235

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:
ARMED SERVICES
RANKING, PERSONNEL SUBCOMMITTEE
FOREIGN AFFAIRS
EDUCATION AND LABOR
HOUSE POLICY

Congress of the United States
House of Representatives

COUNTIES:
AIKEN*
ALLENDALE
BARNWELL
BEAUFORT
CALHOUN*
HAMPTON
JASPER
LEXINGTON
ORANGEBURG*
RICHLAND*
(*PARTS OF)

W. ERIC DELL
CHIEF OF STAFF
AND COUNSEL

July 11, 2012

The Honorable Anthony Keck
Director, S. C. Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

RE: Ellis R. Reynolds, 51 Troon Way, Aiken, SC 29803

Dear Director Keck,

I am writing to you on behalf of the above named constituent who has contacted me regarding an issue involving potential irregularities in his Medicare billing. Enclosed is correspondence from the constituent further explaining the concerns. Your kind attention in this matter would be greatly appreciated.

It is an honor to represent the people of the Second Congressional District, and I value your input. Thank you for your time and concern in this and all other matters.

Please respond to the Aiken District Office at 1555 Richland Ave E, Suite 700, Aiken, South Carolina 29801. The phone number is 803-608-9747. The e-mail address is Ted.Felder@mail.house.gov.

Very truly yours,

Joe Wilson

JOE WILSON
Member of Congress

JW/TF

MIDLANDS OFFICE:
1700 SUNSET BLVD. (US 378), SUITE 1
WEST COLUMBIA, SC 29169
(803) 939-0041
FAX: (803) 939-0078

212 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4002
(202) 225-2452
FAX: (202) 225-2455
www.joewilson.house.gov

LOWCOUNTRY OFFICE:
903 PORT REPUBLIC STREET
P.O. BOX 1538
BEAUFORT, SC 29901
(843) 521-2530
FAX: (843) 521-2535

TOLL FREE 1-888-381-1442

CONGRESSMAN JOE WILSON

Second District of South Carolina

Privacy Release

Consent for Release of Personal Records by Executive Agencies

To Whom It May Concern:

I have sought assistance from the Office of Congressman Joe Wilson on a matter that may require the release of information maintained by your agency, and which may be prohibited from dissemination under the Privacy Act of 1974. I hereby authorize you to release all relevant portions of my records or to discuss information involved in this case with Congressman Wilson or any authorized member of his staff until the matter is resolved.

Name of Agency: Medicare

X Ellis R. Reynolds
Name (please print)

X 10-19-1944
Date of Birth

X
Address City Zip

X 51 Troon WAY · AIKEN, SC. 29803
Social Security Number E-mail Address

X 247-74-6835
Telephone Number - Home

803 649-1657
Telephone Number – Cell

X Ellis R. Reynolds
Signature

July 9 2012
Today's Date

Please briefly explain your concern (use the back if necessary):

Concerns with Medicare Billing. Potential irregularities.

Congressman Joe Wilson (SC-02)
1700 Sunset Boulevard, Suite 1 | West Columbia, SC 29169
Phone: (803) 939-0041 | Fax: (803) 939-0078

Columbia, SC 29219

Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688318 000881
0003 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C707492U-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID: Sent to Provider	WHAT YOU OWE PROVIDER: The provider can bill you for this amount if you have not yet paid.
138.00	19.62	.00

To date, you have satisfied .00 of the 200.00 deductible for the benefit period that began 01/01/2011.
We paid a total of 416.80 for this person this benefit period.

Medicare paid 78.47. We have paid 19.62. You owe your provider .00.

MEDICARE COORDINATED CLAIM

Provider	ALLEN L SLOAN MD P			
Network Participation	YES			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	138.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	19.62			
Total Benefit Allowed	19.62			
Medicare Approved AMT	98.09			
Medicare Paid	78.47			
We Paid	19.62			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!
www.SouthCarolinaBlues.com

Columbia, SC 29219

Blue Cross and Blue Shield Association

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THIS IS NOT A BILL

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BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688818 0000881 0003 OF 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C707492U-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID: Sent to Provider	WHAT YOU OWE PROVIDER: The provider can bill you for this amount if you have not yet paid.
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MEDICARE COORDINATED CLAIM

Provider	ALLEN L SLOAN MD P			
Network Participation	YES			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	138.00			
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Copay/Spec Deductible	.00			
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Total Benefit Allowed	19.62			
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We Paid	19.62			

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Columbia, SC 29219

Blue Cross and Blue Shield Association

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1-800-868-2520 OR
LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

6883318 0000881 0003 of 0004

March 16, 2011

STATE HEALTH PLAN — SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C707492U-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID: Sent to Provider	WHAT YOU OWE PROVIDER: The provider can bill you for this amount if you have not yet paid.
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MEDICARE COORDINATED CLAIM

Provider	ALLEN L SLOAN MD P			
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Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	138.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	19.62			
Total Benefit Allowed	19.62			
Medicare Approved AMT	98.09			
Medicare Paid	78.47			
We Paid	19.62			

* Please refer to the remarks section.

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THANK YOU FOR ALLOWING US TO SERVE YOU!
www.SouthCarolinaBlues.com

Medicare Summary Notice

March 10, 2011

ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

686142 250283
0001 of 0002

CUSTOMER SERVICE INFORMATION

Your Medicare Number: XXX-XX-6835A

If you have questions, call 1-800 MEDICARE (1-800-633-4227) (#00880)

Ask for Doctor's Services
TTY for Hearing Impaired: 1-877-486-2048

Appeals Address: Please see the General Information Section

BE INFORMED: Always read the front and back of your Medicare Summary Notice.

This is a summary of claims processed from 12/27/2010 through 03/08/2011.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02-11055-276-650						
Allen L Sloan MD PC, 1168 W Martintown Rd, N Augusta, SC 29841-2046						b
Referred by: Meredith, Randall M						
Dr. Sloan, Allen L. M.D.						
02/17/11	1.0 Office/outpatient visit new (99203)	$138.00	$98.09	$78.47	$19.62	
02/17/11	10.0 Drug screen multip class (G0431-QW)	280.00	0.00	0.00	0.00	a
02/17/11	10.0 Drug screen multip class (G0431-QW)	280.00	0.00	0.00	0.00	a
	Claim Total	$698.00	$98.09	$78.47	$19.62	
Claim number 02-10349-240-780						
Primary Care Of Aiken, LLC, PO Box 5719, Aiken, SC 29804-5719						b
Dr. Kulik, Ann M. M.D.						
11/23/10	1.0 Office/outpatient visit est (99214)	$120.00	$96.56	$77.25	$19.31	

EOF 28/2134/061

THIS IS NOT A BILL - Keep this notice for your records.

Medicare Summary Notice

March 10, 2011

ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

6861422 250283
0001 OF 0002

CUSTOMER SERVICE INFORMATION

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Allen L Sloan MD PC, 1168 W Martintown Rd, N Augusta, SC 29841-2046						b
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02/17/11	10.0 Drug screen multip class (G0431-QW)	280.00	0.00	0.00	0.00	a
	Claim Total	**$698.00**	**$98.09**	**$78.47**	**$19.62**	
Claim number 02-10349-240-780						
Primary Care Of Aiken, LLC, PO Box 5719, Aiken, SC 29804-5719						b
Dr. Kulik, Ann M. M.D.						
11/23/10	1.0 Office/outpatient visit est (99214)	$120.00	$96.56	$77.25	$19.31	

THIS IS NOT A BILL - Keep this notice for your records.

46523

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688118 000881
0004 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C730246U-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID: Sent to Provider	WHAT YOU OWE PROVIDER: The provider can bill you for this amount if you have not yet paid.
361.00	10.21	.00

To date, you have satisfied .00 of the 200.00 deductible for the benefit period that began 01/01/2011.
We paid a total of 439.45 for this person this benefit period.

Medicare paid 40.82. We have paid 10.21. You owe your provider .00.

MEDICARE COORDINATED CLAIM

Provider	AUGUSTA PHYSICIANS			
Network Participation	NO			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	361.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	10.21			
Total Benefit Allowed	10.21			
Medicare Approved AMT	51.03			
Medicare Paid	40.82			
We Paid	10.21			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!
www.SouthCarolinaBlues.com

EXPLANATION OF BENEFITS

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MON. - FRI. 8:00 A.M. - 6:00 P.M.

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

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STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C730246U-00-00

TOTAL CHARGE FOR YOUR CLAIM	TOTAL AMOUNT WE PAID Sent to Provider	WHAT YOU OWE PROVIDER. The provider can bill you for this amount if you have not yet paid.
361.00	10.21	.00

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We paid a total of 439.45 for this person this benefit period.

Medicare paid 40.82. We have paid 10.21. You owe your provider .00.

MEDICARE COORDINATED CLAIM

Provider	AUGUSTA PHYSICIANS			
Network Participation	NO			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	361.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	10.21			
Total Benefit Allowed	10.21			
Medicare Approved AMT	51.03			
Medicare Paid	40.82			
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BARBARA C REYNOLDS
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AIKEN SC 29803

688318 000881
0003 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1G707492U-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID: Sent to Provider	WHAT YOU OWE PROVIDER: The provider can bill you for this amount if you have not yet paid.
138.00	19.62	.00

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MEDICARE COORDINATED CLAIM

Provider	ALLEN L SLOAN MD P			
Network Participation	YES			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	138.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	19.62			
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BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688318 000881
0004 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C730246U-00-00

TOTAL CHARGE FOR YOUR CLAIM	TOTAL AMOUNT WE PAID	WHAT YOU OWE PROVIDER
361.00	10.21 Sent to Provider	.00 The provider can bill you for this amount if you have not yet paid.

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MEDICARE COORDINATED CLAIM

Provider	AUGUSTA PHYSICIANS			
Network Participation	NO			
Dates of Service	02/17/11			
Type of Service	MEDICAL SERVICES			
Charge	361.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
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Medicare Approved AMT	51.03			
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www.SouthCarolinaBlues.com

Medicare Summary Notice

March 10, 2011

ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

6861422502830001 of 0002

CUSTOMER SERVICE INFORMATION

Your Medicare Number: XXX-XX-6835A

If you have questions, call 1-800 MEDICARE (1-800-633-4227) (#00880)

Ask for Doctor's Services
TTY for Hearing Impaired: 1-877-486-2048

Appeals Address: Please see the General Information Section

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This is a summary of claims processed from 12/27/2010 through 03/08/2011.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02-11055-276-650						
Allen L Sloan MD PC, 1168 W Martintown Rd, N Augusta, SC 29841-2046						b
Referred by: Meredith, Randall M						
Dr. Sloan, Allen L. M.D.						
02/17/11	1.0 Office/outpatient visit new (99203)	$138.00	$98.09	$78.47	$19.62	
02/17/11	10.0 Drug screen multip class (G0431-QW)	280.00	0.00	0.00	0.00	a
02/17/11	10.0 Drug screen multip class (G0431-QW)	280.00	0.00	0.00	0.00	a
	Claim Total	**$698.00**	**$98.09**	**$78.47**	**$19.62**	
Claim number 02-10349-240-780						
Primary Care Of Aiken, LLC, PO Box 5719, Aiken, SC 29804-5719						b
Dr. Kulik, Ann M. M.D.						
11/23/10	1.0 Office/outpatient visit est (99214)	$120.00	$96.56	$77.25	$19.31	

JOHN M DOWNEY, D.O.
ROYAL PAIN CENTER PC
PO BOX 212959
AUGUSTA, GA 30917-2959

(706)855-2767

DATE	ACCOUNT NUMBER
Jun 30, 2011	12284-01

AMOUNT PAID _____

Next Appt:

RESPONSIBLE PARTY

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

PATIENT

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

FOR PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	TREATMENT CODE	UNITS	DESCRIPTION	PLACE OF SERV	PROVIDER	CHARGES	PAYMENTS	INS BILLED
05/31/11			Previous Balance			158.81		

	LAST PAYMENT DATE	LAST PAYMENT AMOUNT	CURRENT	30-60	61-90	91-120	OVER 120	TOTAL DUE
Ins	12/08/10	143.72	0.00	55.71	0.00	55.29	19.41	
Pat	11/13/08	10.00	0.00	0.00	0.00	0.00	28.40	28.40

There are Charges that have NOT been posted in our database for May. Please call Kirstie at (706) 855-2767 ext. #18 if you have any questions

PAYMENT DUE UPON RECEIPT

PATIENT NAME: ELLIS R REYNOLDS

ACCOUNT NUMBER: 12284-01

JOHN M DOWNEY, D.O.
ROYAL PAIN CENTER PC
PO BOX 212959
AUGUSTA, GA 30917-2959

(706)855-2767

DATE	ACCOUNT NUMBER
May 26, 2011	12284-01

AMOUNT PAID _____

Next Appt:

RESPONSIBLE PARTY

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

PATIENT

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

FOR PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	TREATMENT CODE	UNITS	DESCRIPTION	PLACE OF SERV	PROVIDER	CHARGES	PAYMENTS	ADJUSTMENTS
02/01/11			Previous Balance			158.81		

	LAST PAYMENT DATE	LAST PAYMENT AMOUNT	CURRENT	30-60	60-90	90-120	OVER 120	TOTAL DUE
Ins	12/06/10	143.72	0.00	55.71	0.00	55.29	19.41	
Pat	11/13/08	10.00	0.00	0.00	0.00	0.00	28.40	28.40

There are Charges that have NOT been posted in our database for May. Please call Sandy at (706) 855-2767 ext. #28 if you have any questions
PAYMENT DUE UPON RECEIPT

PATIENT: ELLIS R REYNOLDS

ACCOUNT #: 12284-01

Your Medicare Number: XXX-XX-6835A

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	Se Not Sect
	Claim number 11-10320-815-910 Royal Pain Center PC, Pob 212959, Augusta, GA 30917-2959 Referred by: Meredith, Randall M Dr. Downey, John M. M.D.					b
10/14/10	1.0 office/outpatient visit est (99214-25)	$150.00	$97.05	$77.64	$19.41	a
10/14/10	1.0 drain/inject joint/bursa (20605-59LT)	120.00	53.65	42.92	10.73	a
10/14/10	1.0 drain/inject joint/bursa (20605-5951RT)	120.00	26.83	21.46	5.37	a,c
10/14/10	1.0 ketorolac tromethamine inj (J1885)	10.00	0.30	0.24	0.06	a
10/14/10	1.0 lidocaine injection (J2001)	15.00	0.00	0.00	0.00	d,e,
10/14/10	1.0 triamcinolone acet inj nos (J3301)	5.00	1.55	1.24	0.31	a
10/14/10	1.0 vitamin b12 injection (J3420)	1.00	0.28	0.22	0.06	a
	Claim Total	$421.00	$179.66	$143.72	$35.94	
	Claim number 11-10306-825-100 Royal Pain Center PC, Pob 212959, Augusta, GA 30917-2959 Referred by: Meredith, Randall M Dr. Downey, John M. M.D.					b,g
10/27/10	1.0 Pt evaluation (97001-GP)	$100.00	$70.48	$56.38	$14.10	a
10/27/10	1.0 Therapeutic exercises (97110-GP)	50.00	28.36	22.69	5.67	a
	Claim Total	$150.00	$98.84	$79.07	$19.77	

Notes Section:

a The approved amount is based on a special payment method.

b This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. Your private insurer(s) is BCBS OF SOUTH CAROLINA.

c This surgery was reduced because it was performed with another surgery on the same day.

(continued)

I question all charged amounts for past 5 mos.
Ins. Co charged for deadly drugs!
I called both ins. Co's to report fraud —
both Co reps. replied: "they didn't care"!
Please investigate! Health for [illegible]

0038001

JOHN M DOWNEY, D.O.
ROYAL PAIN CENTER PC
PO BOX 212959
AUGUSTA, GA 30917-2959

(706)855-2767

DATE	ACCOUNT NUMBER
Jan 18, 2011	12284-01

AMOUNT PAID _____

Next Appt:

RESPONSIBLE PARTY

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

PATIENT

ELLIS R REYNOLDS
51 TROON WAY
Aiken, SC 29803

FOR PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	TREATMENT CODE	UNITS	DESCRIPTION	PLACE OF SERV	MODIFIER	CHARGES	PAYMENTS	INS PAID
10/14/10			Previous Balance					
10/27/10	97001-GP	1	PHYSICAL THERAPY EVALUATION	11	01	233.69		
10/27/10	97110-GP	1	THERAPEUTIC OFFICE VISIT	11	01	100.00		X
10/18/10	M/CARE		GA MEDICARE			50.00		X
10/18/10	m/care		GA MEDICARE				-77.64	
10/14/10	99214-25	1	Office-Est Patient; Detailed	11	01	150.00	-52.95	X
10/14/10	20605-59LT	1	Joint-medium/ Bursa Injection - The pati	11	01	120.00		X
10/14/10	20605-5951RT	1	Joint-medium/ Bursa Injection - The pati	11	01	120.00		X
10/14/10	J1885	1	Ketorolac 30mg	11	01	10.00		X
10/14/10	J2001	1	Lidocaine Hcl 1.5 cc	11	01	15.00		X
10/14/10	J3301	1	Kenalog-10 0.25cc -.50 cc	11	01	5.00		X
10/14/10	J3420	1	Vitamin B-12 0.25 cc	11	01	1.00		X
11/22/10	M/CARE		GA MEDICARE					
11/22/10	m/care		GA MEDICARE				-79.07	
12/08/10	M/CARE		GA MEDICARE				-51.16	
12/08/10	m/care		GA MEDICARE				-143.72	
							-241.34	

	LAST PAYMENT DATE	LAST PAYMENT AMOUNT	CURRENT	30 DAYS	60 DAYS	90 DAYS	OVER 120 DAYS	TOTAL DUE
Ins	12/08/10	143.72	0.00	55.71	0.00	55.29	19.41	
Pat	11/13/08	10.00	0.00	0.00	0.00	0.00	28.40	28.40

There are Charges and Payments that have NOT been posted in our database for January 2011. Please call Sandy at (706) 855-2706 ext #28 if you have any questions
PAYMENT DUE UPON RECEIPT

PATIENT: ELLIS R REYNOLDS

ACCOUNT #: 12284-01

Claim Number: 1C707492U-00-00			PROVIDER: ALLEN L SLOAN MD P PARTICIPATING PROVIDER			Date(s) of Service: 02/17/11		Amount Provider May Bill You 0.00	
Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
138.00		0.00	19.62	19.62	98.09	78.47	19.62		19.62

To date, you have satisfied 0.00 of the 200.00 deductible for the benefit period that began 01/01/2011. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 0.00 of the 0.00 out-of-pocket maximum for this benefit period. We paid a total of 416.80 for this person this benefit period.

Claim Number: 1C701660U-00-00			PROVIDER: BROWN AND RADIOLOG NON-PARTICIPATING PROVIDER			Date(s) of Service: 01/25/11		Amount Provider May Bill You 0.00	
Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
320.00		0.00	12.44	12.44	62.21	49.77	12.44		12.44

To date, you have satisfied 0.00 of the 200.00 deductible for the benefit period that began 01/01/2011. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 0.00 of the 0.00 out-of-pocket maximum for this benefit period. We paid a total of 429.24 for this person this benefit period.

Claim Number: 1C730246U-00-00			PROVIDER: AUGUSTA PHYSICIANS NON-PARTICIPATING PROVIDER			Date(s) of Service: 02/17/11		Amount Provider May Bill You 0.00	
Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
361.00		0.00	10.21	10.21	51.03	40.82	10.21		10.21

To date, you have satisfied 0.00 of the 200.00 deductible for the benefit period that began 01/01/2011. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 0.00 of the 0.00 out-of-pocket maximum for this benefit period. We paid a total of 439.45 for this person this benefit period.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at
1-800-868-2520 OR
LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688318 000881
0001 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011
Check No.: 0001914093

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ELLIS REYNOLDS	SPOUSE	ZCS08393041	1C730304U-00-00

TOTAL CHARGE FOR YOUR CLAIM	TOTAL AMOUNT WE PAID	WHAT YOU OWE PROVIDER(S)
125.00	22.55	.00
	Payment Enclosed	The provider(s) can bill you for this amount if you have not yet paid.

To date, you have satisfied .00 of the 200.00 deductible for the benefit period that began 01/01/2010.
We paid a total of 1,377.41 for this person this benefit period.

Medicare paid 90.19. We have paid 22.55. You owe your provider .00.

MEDICARE COORDINATED CLAIM

Provider	YOUR PROVIDER			
Network Participation	NO			
Dates of Service	05/13/10			
Type of Service	OFFICE PSYCHIATRIC			
Charge	125.00			
Medicare Deductible	.00			
Copay/Spec Deductible	.00			
Medicare Coinsurance	22.55			
Total Benefit Allowed	22.55			
Medicare Approved AMT	112.74			
Medicare Paid	90.19			
We Paid	22.55			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!
www.SouthCarolinaBlues.com

SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

This is important information about services BARBARA C REYNOLDS received. The following information shows how much we covered and how much you may owe your provider for services received.

Patient: BARBARA C REYNOLDS	ID: ZCS08393041	Patient Relationship to Policyholder: SELF

Claim Number: 0D673510V-00-00			PROVIDER: RICHARD S CHESSER PARTICIPATING PROVIDER			Date(s) of Service: 05/25/10		Amount Provider May Bill You 0.00	
Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
100.00		0.00	19.08	19.08	95.40	76.32	19.08		19.08

To date, you have satisfied 0.00 of the 200.00 deductible for the benefit period that began 01/01/2010. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 0.00 of the 0.00 out-of-pocket maximum for this benefit period. We paid a total of 328.49 for this person this benefit period.

This is important information about services ELLIS REYNOLDS received. The following information shows how much we covered and how much you may owe your provider for services received.

Patient: ELLIS REYNOLDS	ID: ZCS08393041	Patient Relationship to Policyholder: SPOUSE

Claim Number: 0D540448U-00-00			PROVIDER: KROGER CO NON-PARTICIPATING PROVIDER			Date(s) of Service: 05/05/10 - 07/18/10		Amount Provider May Bill You 0.00	
Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
174.79		0.00	23.27	23.27	116.37	93.10	23.27		23.27

To date, you have satisfied 0.00 of the 200.00 deductible for the benefit period that began 01/01/2010. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 0.00 of the 0.00 out-of-pocket maximum for this benefit period. We paid a total of 602.24 for this person this benefit period.

Claim Number: 0D607650U-00-00		PROVIDER: AUGUSTA PAIN MANAG NON-PARTICIPATING PROVIDER			Date(s) of Service: 05/24/10		Amount Provider May Bill You 18.99	
Your Provider Charged	Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
150.00	0.00	18.99	0.00	94.96	75.97	0.00		0.00

To date, you have satisfied [0.00] of the [200.00] deductible for the benefit period that began [01/01/2010]. This claim contributed [0.00] toward your out-of-pocket maximum. You have satisfied [0.00] of the [0.00] out-of-pocket maximum for this benefit period. We paid a total of [602.24] for this person this benefit period.

Claim Number: 0D676279U-00-00		PROVIDER: THE FOOT AND ANKLE NON-PARTICIPATING PROVIDER			Date(s) of Service: 05/24/10		Amount Provider May Bill You 0.00	
Your Provider Charged	Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
62.00	0.00	12.40	12.40	62.00	49.60	12.40		12.40
81.00	0.00	16.20	16.20	81.00	64.80	16.20		16.20
24.00	0.00	4.80	4.80	24.00	19.20	4.80		4.80
28.00	0.00	5.60	5.60	28.00	22.40	5.60		5.60
TOTAL:								
195.00	0.00	39.00	39.00	195.00	156.00	39.00		39.00

To date, you have satisfied [0.00] of the [200.00] deductible for the benefit period that began [01/01/2010]. This claim contributed [0.00] toward your out-of-pocket maximum. You have satisfied [0.00] of the [0.00] out-of-pocket maximum for this benefit period. We paid a total of [641.24] for this person this benefit period.

* REMARKS:

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

(1) THIS AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE AMOUNT FOR THIS SERVICE.

(2) YOUR BENEFIT PLAN DOES NOT COVER SERVICES RENDERED BY THIS PROVIDER, OR THIS PROVIDER WAS NOT ACTIVE IN OUR FILES ON THIS DATE OF SERVICE. PLEASE REFER TO THE EXCLUSIONS OR DEFINITIONS SECTIONS OF YOUR BENEFIT BOOKLET FOR SPECIFIC DETAILS.

Brenda James

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:31 AM
To: Brenda James
Subject: Log 0020 Email Closure
Attachments: Cong. Wilson - Ann Marie Beason.pdf

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:30 AM
To: 'ted.felder@mail.house.gov'
Cc: 'mcdong@aging.sc.gov'
Subject: Congressman Wilson Constituent Letter - Ann-Marie Beason

Mr. Felder,

The attached letter that was referred to our office is regarding a Medicare issue rather than Medicaid. Since this department does not handle Medicare billing, I am copying Gloria McDonald on this email to determine if the Office on Aging can assist with this matter. Gloria: Please research and respond back to Mr. Felder regarding this matter.

Thanks,

Jenny Lynch
Legislative Affairs
SC Department of Health and Human Services
Office: (803) 898-3965
Cell: (803) 351-5673
Fax: (803) 255-8235