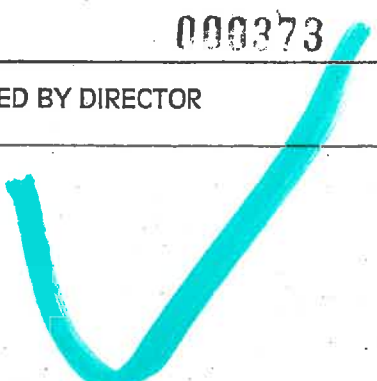



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton/Amick</i>	DATE <i>5-29-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000373</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>6-7-13</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. 			
3.			
4.			

LINDSEY O. GRAHAM
SOUTH CAROLINA



290 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-5972

UNITED STATES SENATE

May 21, 2013

RECEIVED

MAY 28 2013

Mr. Anthony Keck
Director
S.C. Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Department of Health & Human Services
OFFICE OF THE DIRECTOR

RE: Mr. Roger Thomas
SSN: 282-52-6374

Dear Mr. Keck:

Enclosed is a copy of correspondence I have received from the above named constituent. I believe you will find it self-explanatory.

Your reviewing this material and providing any assistance or information possible under the governing statutes and regulations will be greatly appreciated. Thank you for your attention in this matter. I look forward to hearing from you soon.

Sincerely,

A handwritten signature in black ink, appearing to read "Lindsey", written over a horizontal line.

Lindsey O. Graham
United States Senator

LOG/lt

Enclosure

Please reply to: Senator Lindsey Graham
530 Johnnie Dodds Boulevard, Suite 202
Mt Pleasant, South Carolina 29464

AUTHORIZATION FORM

By providing the information below and signing this form, I hereby authorize _____ (agency name) to furnish the office of U.S. Senator Lindsey Graham information pertaining to my claim or request. This authorization is in accordance with the Privacy Act of 1974.

Name: Roger Thomas Phone: 843-871-5194

Address: 110 Jennings Dr.

City: Summerville State: S.C. Zip: 29483

Social Security Number: 282-52-6374 A Number (if applicable): _____

In the space below, briefly describe the problems that you are experiencing and explain exactly what you would like Senator Graham to do on your behalf. Without this information, it will be impossible for Senator Graham to adequately assist you. (If you need more space, please use the back of the form).

I was told by Doctor I need to
increase my Med. (Gemfibrozil) to control
my (Triglycerides) that I was going to have
a Stroke or Heart Attack, Since my
mom had this he believes a lot is inherited
I watch My diet and Exercise (More on Back)

Signed: Roger Thomas Date: 05-2013

NOTE: Those requesting assistance from Senator Graham should note that if they are represented by an attorney, that attorney must contact the Senator's office by letter or telephone before action can proceed. This is to eliminate any confusion and it is in the best interest of the client.

If represented by an attorney, please give attorney's name _____

Please return form to:

U.S. Senator Lindsey O. Graham
530 Johnnie Dodds Boulevard, Suite 202
Mt. Pleasant, South Carolina 29464
Phone: (843) 849-3887
Fax: (843) 971-3669

My Dr. wrote Medical and even wrote
to them to No Avail, find their response
to me attached. Just a note I am 59
and worked hard labor jobs from a
teenager if you can help I don't want
to die I don't know where else to
turn.

Thank you

Roger Thomas

My Doctor address
Below

9228 Medical Plaza Drive
Charleston, SC 29406



**Trident
Family Health**

(843) 572-8277 (phone)
(843) 764-2669 (fax)

Trident Family Health
Clinical Summary for 04/01/2013

PATIENT NAME: Roger Thomas

ACCOUNT#: 107074

MRNO#: 107074

DOB: 02/20/1954

APPOINTMENT: With Richard Wilkes, MD at 02:00 PM for Return Visit

Location: OFFICE, 9228 MEDICAL PLAZA DR CHARLESTON, SC 29406 Phone: 843/572-8277

5/2/2013

ROGER THOMAS
110 JENNINGS DR
SUMMERVILLE, SC 29483

Dear ROGER THOMAS:

First Choice has reviewed Richard Wilkes's request for GEMFIBROZIL 600 MG TABLET. The request is denied due to the following reason(s):

GEMFIBROZIL 600 MG TABLET dosed 3 daily is not covered because the maximum recommended dose of GEMFIBROZIL 600 MG TABLET according to the medical compendia (Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), Drug Package Insert) as defined in the Social Security Act 1927 and/or per Standard of Care Guidelines is 1200 MG per day (2 tablets daily). Documentation submitted does not support exceeding this maximum recommended dose. We will approve the following dosage of the requested medication: GEMFIBROZIL 600 MG TABLET dosed 2 tablets daily.

You (or someone you name) may appeal this decision within 90 calendar days. The 90 days start with the date on this letter. You have the chance to present evidence, and details of fact or law in an appeal.

If you want to name someone to appeal for you, you must give them written permission. Permission to appeal cannot be given before the services are requested. You are not required to give your doctor permission to appeal on your behalf as a condition of receiving care.

You may make an appeal in two ways:

1. You may make an oral (phone) appeal. This is done by calling First Choice. The toll-free number is 1.888.276.2020. You need to confirm this with a written, signed appeal unless you are requesting an expedited (quick) decision.
2. You may make your appeal in writing. The written appeal must be signed and sent with a copy of this letter to:

Select Health of South CarolinaB
Member Services
P.O. Box 40849
Charleston, SC 29423-0849

Decisions will be made within 30 calendar days. An expedited (quick) decision may be made within 3 business days. You may call First Choice and request this. The toll-free number is 1.888.276.2020. Decisions are expedited (quick) if it is decided that waiting the standard time frame could seriously jeopardize (risk):

- Life or health,
- Or the ability to attain, maintain or regain maximum function.

You also have the right to request a State Fair Hearing. You may request this after the appeal process with First Choice has been exhausted. We will tell you how to request a hearing when you get the final appeal decision.

You have the right to continue benefits while an appeal is pending. You must ask for this **within**:

- 10 calendar days from this letter date
- Or 10 calendar days from when your services are stopped.

You may call First Choice and ask that your benefits continue. The toll-free number is 1.888.276.2020. Please note that you may have to pay the costs of these services. This could happen if the final appeal decision is to deny services.

You or someone you name may examine the case file, including a copy of the guideline used to make this decision. You may call First Choice to ask for this. The toll-free number is 1.888.276.2020.

A letter has also been sent to Richard Wilkes telling how to appeal this decision or how to speak with our Medical Director.

Thank you,

Pharmacy Services Department

