DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	5-7-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000705	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Singleton, ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

May 3, 2007

Ms. Sandra Tyner
Morphis Pediatrics Group Lancaster
838 W. Meeting St., Suite A
Lancaster, SC 29720

Re: RHC CMS Certification Number (CCN): **42-8916**

Dear Ms. Tyner:

Your request to withdraw from the Health Insurance for the Aged and Disabled Program (Medicare) as a provider of services has been accepted. Accordingly, your agreement with the Secretary of Health and Human Services terminated **May 1, 2007.**

In accordance with your Health Insurance Benefits agreement, public notice of this voluntary termination is necessary. Please publish a notice in the local newspaper with the widest circulation as soon as possible. The notice should be along the following lines:

> Morphis Pediatrics Group Lancaster will no longer participate in the Medicare Program (Title XVIII of the Social Security Act) effective **May 1, 2007**. The agreement between Morphis Pediatrics Group Lancaster and the Secretary of Health and Human Services terminated on **May 1, 2007** in accordance with the provisions of the Social Security Act.
>
> The Medicare program will not make payment for services furnished to beneficiaries who were admitted on or after **May 1, 2007**. For beneficiaries admitted prior to **May 1, 2007** payment is available for up to 30 days for care furnished under a plan established before the effective date of termination for Rural Health Clinics Services.
>
> Name of authorized official
> Name of institution

Please provide our office with a copy of the newspaper notice. Send to: Atlanta Federal Center, CMS, Region IV, 61 Forsyth Street, S.W., Suite 4T20, Atlanta, Georgia 30303-8909. You should be in touch with **Riverbend Government Benefits Administrators (00390)** to make arrangements for completing a final cost report and to adjust any outstanding current financing or accelerated emergency payments. They have been notified of this action by copy of this letter.

Should you have any questions concerning this matter, please contact Willie Tucker at (404) 562-7470.

Sincerely,

/s/

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

NOTE TO THE FISCAL INTERMEDIARY:
THIS LETTER REPLACES THE HCFA-2007, PROVIDER TIE-IN NOTICE.