

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>7-15-11</i>
------------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>11011035</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Hess</i> <i>cleared 7/19/11, letter attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>7-26-11</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.			
2.			
3.			
4.			

From: Bryan Kost
To: Brenda James
Date: 07/14/2011 5:12 PM
Subject: Please log -Fw: Fwd: Medicaid Lien Amount Request (Forward from Info ID)
Attachments: Fwd: Medicaid Lien Amount Request (Forward from Info ID)

RECEIVED

JUL 15 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Brenda James - Medicaid Lien Amount Request

From: "chris@lempesis-law.com" <chris@lempesis-law.com>
To: "info@scdhhs.gov" <info@scdhhs.gov>
Date: 07/14/2011 5:01 PM
Subject: Medicaid Lien Amount Request
Attachments: Medicaid Lien amount request.pdf

Christopher W. Lempesis, Jr.
Attorney at Law

Mail to:
P.O. Box 43
Beaufort, SC
29901

P: (843) 321-9529
F: (888) 663-9627
E: chris@lempesis-law.com

July 14, 2011

South Carolina Medicaid
Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206

RECEIVED

JUL 15 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

VIA FAX: 803-255-8225
VIA EMAIL: info@scdhhs.gov

Ref: Medicaid Recipient: Shewanda Denise Tolen
SSN: ENCLOSED
Date of Accident: February 4, 2011
Description of Loss: Slip and Fall in Dollar General

Re: Lien Amount Request.

Dear Sir or Madam,

I represent the above referenced individual in connection with her claims arising from a slip and fall in Dollar General on February 4, 2011.

I have faxed a lien amount request and reduction request to your office. I am happy to email the same if you could please provide me a direct email address so that I send my client's personal information to a secure email address.

Thank you.

With kind regards,

Chris Lempesis

Christopher W. Lempesis, Jr., Attorney at Law

P.O. Box 43
Beaufort, SC 29901
P: (843) 321-9529
F: (888) 663-9627 (Toll-Free)
www.Lempesis-Law.Com

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Christopher W. Lempesis, Jr.
Attorney at Law

Mail to: P: (843) 321-9529
P.O. Box 43 F: (888) 663-9627
Beaufort, SC 29901 E: chris@lempesis-law.com

FAX

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JUL 15 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Date: 7/14/2011

Fax:: 803-255-8225

To: South Carolina Medicaid
Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206
P: (803) 898-2500
E: info@scdhhs.gov

Ref: Medicaid Recipient: Shewanda Denise Tolen
SSN: ENCLOSED
Date of Accident: February 4, 2011
Description of Loss: Slip and Fall in Dollar General

Re: Lien Amount Request

Pages (total): 4

Dear Sir or Madam,

Please see the attached pages.

With kind regards,

Chris Lempesis

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Christopher W. Lempesis, Jr.
Attorney at Law

Mail to: P: (843) 321-9529
P.O. Box 43 F: (888) 663-9627
Beaufort, SC 29901 E: chris@lempesis-law.com

July 14, 2011

South Carolina Medicaid
Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206

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JUL 15 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

VIA FAX: 803-255-8225
VIA EMAIL: info@scdhhs.gov

Ref: Medicaid Recipient: Shewanda Denise Tolen
SSN: ENCLOSED
Date of Accident: February 4, 2011
Description of Loss: Slip and Fall in Dollar General

Re: Lien Amount Request.
Dear Sir or Madam,

I represent the above referenced individual in connection with her claims arising from a slip and fall in Dollar General on February 4, 2011.

I estimate that Ms. Tolen's medical bills covered by Medicaid amount to something in the nature of \$5880.00.

I have agreed to reduce my fee by reducing the amount claimed in order to settle this matter. In the same connection, I hereby request a 75% reduction in any Medicaid liens to reflect a reduced amount reached in settlement of this matter. Applying the requested reduction, I estimate the appropriate lien amount should be somewhere in the nature of \$1470.00.

I have attached a HIPAA Complaint Release and also General Release to this fax.

Please send me the amount of the Lien(s) South Carolina Medicaid asserts against any recovery in this matter based on cost for my client's treatment.

Thank you.

With kind regards,



Christopher W. Lempesis, Jr.

CWL/

Attachment(s): HIPAA Compliant Release and General Release, each signed by Ms. Shewanda Denise Tolen.

Reg #000035 ✓



July 19, 2011

CHRISTOPHER W LEMPESIS ESQUIRE
PO BOX 43
BEAUFORT SC 29901-

Re: Shawanda Tolen
Medicaid No.: 241 119 9401
Date of Accident: February 4, 2011

Dear Mr Lempesis:

Thank you for your request for Medicaid claim information.

Please be advised that South Carolina Department of Health & Human Services will not be presenting a claim, at this time, for the aforementioned recipient because:

- () Claims paid to date do not appear related to the above-referenced accident.
- () Client not Medicaid eligible on the above-referenced date of accident.
- (X) Our research indicates that your client may have received services through a Medicaid **Managed Care Organizations (MCO)**. This office does not provide subrogation information pertaining to the above accident. Please contact the highlighted Medicaid MCO on the attached sheet for subrogation information.
- () **The date of accident is too recent for us to process your request at this time. Please allow an additional 45-60 days for us to efficiently pull claims and process this request.**

If you would like for me to recheck my records prior to final settlement negotiations, please give me a call.

Sincerely,

Deborah Johnson

Division of Third Party Liability
Casualty Department
PO Box 100127 Columbia, SC 29202-3127
Telephone (803) 898-2977 Fax (803) 255-8225



MANAGED CARE ORGANIZATIONS

Health Plans	Telephone	E-mail
Absolute Total Care	1-866-433-6041	www.totalcarolinacare.com
BlueChoice HealthPlan	1-800-574-8864	www.BlueChoiceSCMedicaid.com
Carolina Crescent Health Plan	1-866-748-8661	www.carolinachp.com
First Choice by Select Health of SC	1-888-276-2020	www.selecthealthofsc.com
Unison Health Plan	1-800-414-9025	www.unisonhealthplan.com
South Carolina Solutions	1-888-366-6243	www.sc-solutions.org

SOUTH CAROLINA MEDICAID AGENCY
DEPARTMENT OF HEALTH & HUMAN SERVICES
www.dhhs.state.sc.us

DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF THIRD PARTY LIABILITY
PO BOX 100127,
COLUMBIA, SC 29202-3127