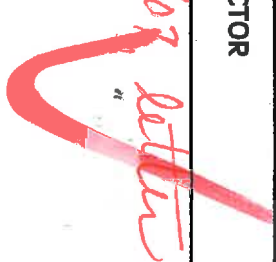


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>GB - Dr Burton</i>	DATE <i>8/11/07</i>
-----------------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <b>000059</b>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Cleared 8/24/07 letter attached.</i> 	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>8/15/07</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.			



# RILEY FAMILY PRACTICE ASSOCIATES, P.A.

PO Box 248, 595 Newberry Highway

Saluda, S.C. 29138

Telephone (864)445-2500 Fax (864)445-3956

O. Marion Burton, M.D.  
Medical Director  
State of South Carolina  
Department of Health and Human Services  
P.O. Box 8206  
Columbia, SC 29202

Please log  
to Dr. B  
C. Sum.

July 30, 2007

Dear Dr. Burton,

Please find enclosed claims with a rejection edit code 977. These patients are individuals from the Saluda Nursing Center Facility and are skilled level of care. We are required to see them every 30 days. Is it necessary to have this edit for Medicare/Medicaid (dual eligibility) if they are in a skilled nursing facility? These patients have acute illnesses that require them to be seen more than the monthly visit. Some may require to be seen several times a month. Most of these patients have no means to pay these bills that will occur after their 12 visits are up. Would you please consider the edit 977 on all nursing center visits? Thank you for your consideration.

Sincerely,

*Ralph N. Riley MD*

Ralph N. Riley, MD  
Riley Family Practice

**RECEIVED**

AUG 01 2007

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Ralph N. Riley, MD Mary H. Dannelly, A.P.R.N.  
Mildred D. Scribbling, A.P.R.N.



ORIGINAL CGN:

ADJ CGN:

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 977

11 DATE OF BIRTH 03/26/1936 12 SEX F

21 22

\*\* AGENCY USE ONLY

\*\* APPROVED EDITS

\*\* REJECTED LINE EDITS

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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

HIC - 22 PRAC SPEC - 97

EDIT CORRECTION FORM

PRV ZIP: 29138

DOC IND N

8 PRIMARY

9 SECONDARY

DIAGNOSIS

PC COORD

EMERG

TPL INJURY

CODE

PROG

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INDIVIDUAL CHARGE

PROVIDER

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RUN DATE 07/17/2007 000022780

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

2

PROVIDER

RECIPIENT

P AUTH

TPL INJURY

CODE

NUMBER

7716972501

RHC022

ID

NPI: 1104970847

10 RECIPIENT NAME - THELMA

B BODIE

13

RES

14

ALLOWED

LN

DATE OF

SERVICE

PLACE

17

PROC

MOD

18

INDIVIDUAL CHARGE

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PAY UNITS

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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

HIC - 22 PRAC SPEC - 97

EDIT CORRECTION FORM

PRV ZIP: 29138

DOC IND N

8 PRIMARY

9 SECONDARY

DIAGNOSIS

PC COORD

EMERG

TPL INJURY

CODE

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INDIVIDUAL CHARGE

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PRV ZIP: 29138

DOC IND N

8 PRIMARY

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DIAGNOSIS

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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

HIC - 22 PRAC SPEC - 97

EDIT CORRECTION FORM

PRV ZIP: 29138

DOC IND N

8 PRIMARY

9 SECONDARY

DIAGNOSIS

PC COORD

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TPL INJURY

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ORIGINAL CGN:  
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ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND M  
SFL ZIP: 29835  
PRV ZIP: 29138  
P AUTH 4  
TFL INJURY 5  
EMERG PC COORD 6  
DIAGNOSIS 8  
PRIMARY SECONDARY  
RHCO22 4047249801  
NPI: 1104970847  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1  
PROVIDER  
2  
RECIPIENT  
ID  
ID  
RHCO22 4047249801  
NPI: 1104970847

10 RECIPIENT NAME - GEORGIA L DUNN  
11 DATE OF BIRTH 10/18/1959 12 SEX F  
13  
14 ALLOWED LN NO  
15 DATE OF SERVICE  
16 PLACE  
17 PROC  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
21  
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23  
NDC

01 620 250136514A 58.20 27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 77583  
02  
03  
RESOLUTION DECISION

ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM



10	RECIPIENT NAME - BOBBY	ANDREWS	SR	11	DATE OF BIRTH	11/05/1935	12	SEX	M
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RES	13	ALLOWED	LN	DATE OF	PLACE	PROC	INDIVIDUAL	CHARGE	PAY	UNITS	APPROVED	EDITS
	14			15	16	17	19	20	21	22		
						18						

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**                                **  
**      REJECTED LINE EDITS      **  
**                                **  
**      APPROVED EDITS           **  
**      AGENCY USE ONLY          **  
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1.00	1	11/24/06	31	T1015	000	RHC022	73.89	1.000
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EDIT          PAYMENT DATE  
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CLAIMS/LINE PAYMENT INFO  
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INS CARR NUMBER	24	INS CARR NUMBER	25	INS CARR NUMBER	26	INS CARR NUMBER	27	TOTAL CHARGE
NPI :	1861472490	TAXONOMY:	2	TAXONOMY:	26	TAXONOMY:	73.89	
NPI :		TAXONOMY:	3	TAXONOMY:				
NPI :		TAXONOMY:	4	TAXONOMY:				
NPI :		TAXONOMY:	5	TAXONOMY:				
NPI :		TAXONOMY:	6	TAXONOMY:				
NPI :		TAXONOMY:	7	TAXONOMY:				
NPI :		TAXONOMY:	8	TAXONOMY:				
NPI :		TAXONOMY:		TAXONOMY:				

01	620	249508440A	58.20	28	AMT REC'D INS	58.20
02				29	BALANCE DUE	15.69
03				30	OWN REF #	138225

**ADDITIONAL DIAG CODES:**

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED" \* INDICATES A SPLIT CLAIM



mc/mid  
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ADJ CGN:  
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INSURANCE EDITS  
CLAIM EDITS

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**
**      REJECTED LINE EDITS
**
**      AGENCY USE ONLY
**      APPROVED EDITS
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13	RES	14	ALLOWED	LN	NO	15	DATE OF SERVICE	16	PLACE	17	PROC CODE	18	MOD	23	NDC	19	INDIVIDUAL PROVIDER	20	CHARGE	21	PAY	22
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RESOLUTION DECISION \_\_\_\_\_

ADDITIONAL DIAG CODES: . . . . .

RETURN TO: MEDICAL CLAIMS RECEIPT

INSURANCE POLICY INFORMATION

MEDICAL CLAIMS RECEIPT  
 P. O. BOX 1412  
 COLUMBIA, S.C. 29202-1412  
 PROVIDER:  
 RILEY FAMILY PRACTICE ASSO  
 PO BOX 248

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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11 DATE OF BIRTH 11/10/1910 12 SEX F  
19 INDIVIDUAL CHARGE 20 PAY UNITS  
21 22  
73.89 1.000  
RHC022  
NDC 23  
05/25/07 31 T1015 000  
NPI: 1861472490  
2  
TAXONOMY:  
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POLICY NUMBER  
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INS CARR PAID  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 17679  
01 620 PD266542124  
02  
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RESOLUTION DECISION

RUN DATE 07/17/2007 000022784  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29835  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY SECONDARY  
719.40  
NPI: 1104970847  
RHC022 2074542501  
ID  
PROVIDER RECIPIENT  
P AUTH TPL INJURY CODE  
NUMBER  
SFL ZIP: 29835  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY SECONDARY  
719.40  
NPI: 1104970847  
RHC022 2074542501  
ID  
PROVIDER RECIPIENT  
P AUTH TPL INJURY CODE  
NUMBER

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1  
PROVIDER ID  
ID  
RHC022  
NPI : 1104970847

10 RECIPIENT NAME - ROBERT SIBERT

05/25/07 1 00  
TAXONOMY: 1861472490

NP1:	2	TAXONOMY:
NP1:	3	TAXONOMY:

INS CAR	24	NUMBER	POLICY	25	NUMBER
NP1	NP1	3	TAXONOMY	3	TAXONOMY
NP1	NP1	4	TAXONOMY	4	TAXONOMY
NP1	NP1	5	TAXONOMY	5	TAXONOMY
NP1	NP1	6	TAXONOMY	6	TAXONOMY
NP1	NP1	7	TAXONOMY	7	TAXONOMY
NP1	NP1	8	TAXONOMY	8	TAXONOMY
NP1	NP1	25	TAXONOMY	25	TAXONOMY

01 620 250469081A 58.20

RESOLUTION DECISION \_\_\_\_\_

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED" \* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/17/2007 000022774  
REPORT NUMBER CLM3500

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

ORIGINAL CGN:  
EMC  
ADJ CGN:

EDITS  
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 977

11 DATE OF BIRTH 07/30/1962 12 SEX M

10 RECIPIENT NAME - DAVID ALLE SANTAY

13	RES	14	ALLOWED	LN	NO	DATE OF	15	SERVICE	16	PLACE	17	PROC	18	MOD	19	INDIVIDUAL	20	CHARGE	21	PAY	22	UNITS	23	NDC
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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
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1	NP1:	1861472490	2	TAXONOMY:	31	05/25/07	3	TAXONOMY:	31	T1015	000	RHC022	73.89	1.000
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NP1: 1861472490

NP1: TAXONOMY:

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INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

ENC  
ORIGINAL CGN:  
ADJ CGN:

EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

01) 977

10 RECIPIENT NAME - MATTIE H ELLIOTT 11 DATE OF BIRTH 03/26/1914 12 SEX F

13 RES 14 ALLOWED 15 DATE OF SERVICE 16 PLACE 17 PROC 18 MOD 19 INDIVIDUAL CHARGE 20 PAY UNITS 21 AGENCY USE ONLY 22 APPROVED EDITS 23 REJECTED LINE EDITS

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PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
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1 NPI: 1861472490 2 TAXONOMY: 3 05/25/07 31 T1015 000 RHCO22 73.89 1.000

01 620 250012415A 58.20 27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 104644135

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER RECIPIENT  
2 ID 1334807401  
3 AUTH TPL INJURY CODE  
4 EMERG PC COORD  
5 PRV ZIP: 29138  
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--- DIAGNOSIS  
PRIMARY SECONDARY  
307.9

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/17/2007 000022773  
REPORT NUMBER CLM3500

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 P AUTH  
4 TPL INJURY CODE  
5 EMERG PC COORD  
6 PRV ZIP: 29138  
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--- DIAGNOSIS  
PRIMARY SECONDARY  
RHC022 2780562808  
NPI: 1104970847

10 RECIPIENT NAME - LILLIAN S RICHARDS

13 RES  
14 ALLOWED  
15 DATE OF SERVICE  
16 PLACE  
17 PROC CODE  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
21 AGENCY USE ONLY  
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23 REJECTED LINE EDITS  
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11 CLAIMS/LINE PAYMENT INFO  
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01 620 248039120A 58.20  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 142926  
02  
03

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

CLAIM CONTROL #0718405428013100A  
PAGE 22370 ECF 22370 PAGE 1 OF 1

EDITS  
INSURANCE EDITS

LINE EDITS

446 (10)

11 DATE OF BIRTH 05/29/1931 12 SEX F

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*****
** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **
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||||| CLAIMS/LINE PAYMENT INFO
||||| EDIT
||||| PAYMENT DATE
|||||

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13	RES	14	ALLOWED	LN	NO	15	DATE OF SERVICE	16	PLACE	17	PROC CODE	18	MOD	19	INDIVIDUAL PROVIDER	20	CHARGE IND	21	PAY	22	UNITS
				1		06/01/07		31	T1015			000		RHC022			73.89				1.000

24	INS CARR	NUMBER	25	POLICY	NUMBER	26	INS CARR	PAID
01 620	249442696A	59.11	27	TOTAL CHARGE	73.89	28	AMT REC'D INS	59.11
02			29	BALANCE DUE	14.78	30	OWN REF #	74492

REPORT NUMBER CLM3500  
RUN DATE 07/17/2007 000022792

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

TAXONOMY:
SIGNON ID
1 PROVIDER
2 RECIPIENT
3 P AUTH TPL INJURY
4 EMERG PC COORD
5 PRIVATE ZIP: 29138
6 PRIMARY
7 SECONDARY
8 DIAGNOSIS
9 RHC022
0334945301
NUMBER CODE
290.0

10 RECIPIENT NAME - MARY

13	RES	14	ALLOWED	LN	NO	15	DATE OF	16	PLACE	17	PROC	18	MOD
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23  
NDC

NP1: 1861472490  
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06/01/07  
31 T1015 000  
TAXONOMY:

	NPI :	Z	/ TAXONOMY:	
	NPI :	3	/ / TAXONOMY:	
	NPI :	4	/ / TAXONOMY:	
	NPI :	5	/ / TAXONOMY:	
	NPI :	6	/ / TAXONOMY:	
	NPI :	7	/ / TAXONOMY:	
	NPI :	8	/ / TAXONOMY:	
	NPI :	25	TAXONOMY:	
INS CARR NUMBER		POLICY NUMBER		26 INS CARR PAID

RESOLUTION DECISION \_\_\_\_\_  
ADDITIONAL DIAG CODES: \_\_\_\_\_

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29

PU BOX 248  
 SALUDA  
 SC 29138-0248  
 \*PLEASE NOTE: EDIT CORRECTION FORMS RETURNED  
 # INDICATES A SPLIT CLAIM

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/17/2007 000022779  
REPORT NUMBER CLM3500

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
PRV ZIP: 29138  
SFL ZIP: 29835  
DIAGNOSIS ---  
PRIMARY SECONDARY  
ID ID  
PROVIDER RECIPIENT  
P AUTH TPL INJURY EMERG PC COORD  
NUMBER CODE  
ID ID  
RHCO22 4780546513  
NPI: 1104970487

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

11 DATE OF BIRTH 06/23/1927 12 SEX M

10 RECIPIENT NAME - HERMAN C BELCHER  
13 RES  
14 ALLOWED  
15 DATE OF SERVICE  
16 PLACE  
17 PROC  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
21 AGENCY USE ONLY  
22 APPROVED EDITS  
23 REJECTED LINE EDITS  
24 NDC  
25 RHCO22 73.89 1.000

CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE

INS CAR NUMBER 24  
NPI: 1861472490  
POLICY NUMBER 25  
TAXONOMY: 26  
INS CAR PAID 26  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 146019

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 06/26/2007 000025084  
REPORT NUMBER CLM3500

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 P AUTH  
4 TPL  
5 INJURY  
6 EMERG  
7 PC COORD  
8 DIAGNOSIS  
9 PRIMARY  
10 SECONDARY  
290.0

ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

10 RECIPIENT NAME - LILLIAN B COCKRELL  
11 DATE OF BIRTH 09/26/1920 12 SEX F

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

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

\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

1 00 05/01/07 31 T1015 000 RHCO22 73.89 1.000

NPI: 1861472490  
TAXONOMY:

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TAXONOMY:

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TAXONOMY:

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TAXONOMY:

25  
TAXONOMY:

26  
INS CAR  
PAID

01 620 251070460A 58.20

02  
03  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 875318

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

mc/mw.  
RHC  
commented

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 06/26/2007 000025080  
REPORT NUMBER CLM3500

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 AUTH  
4 TPL INJURY CODE  
5 EMERG PC COORD  
6 PRV ZIP: 29138  
7  
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DIAGNOSIS  
PRIMARY  
SECONDARY  
782.3

EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

ADJ CGN:  
ORIGINAL CGN:

11 DATE OF BIRTH 09/23/1929 12 SEX F

10 RECIPIENT NAME - MYRTIS ADAMS

13 RES  
14 ALLOWED  
15 DATE OF SERVICE  
16 PLACE  
17 CODE  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
21  
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NDC

RHC022 73.89 1.000

CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE

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

INS CARR  
NUMBER  
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POLICY  
NUMBER  
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INS CARR  
PAID  
26

NP1: 1861472490  
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05/02/07  
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T1015  
000  
RHC022  
73.89  
1.000  
TAXONOMY:  
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RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

01 620 249575862M 58.20  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 141630

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

mc/mrd  
w/attached  
RHC

RUN DATE 06/19/2007 000024845

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

CLAIM CONTROL #0715701875004000A  
PAGE 24768 ECF 24768 PAGE 1 OF 1

REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
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PROVIDER  
RECIPIENT  
P AUTH TPL INJURY EMERG PC COORD  
ID  
ID  
RHCO22 6780556232  
NP1: 1104970847

10 RECIPIENT NAME - BETTY H PATTERSON  
11 DATE OF BIRTH 05/28/1930 12 SEX F 01) 977  
LINE EDITS

13 RES 14 ALLOWED LN NO DATE OF SERVICE PLACE PROC MOD 17 18 19  
INDIVIDUAL CHARGE PAY UNITS  
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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
\*\*\*\*\*

mc/mo  
unsubmitted

01 620 251463507A 58.20 27 TOTAL CHARGE 72.75  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 14.55  
30 OWN REF # 141425  
RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

TAXONOMY: 1  
PROVIDER 2  
ID 3  
RHC022 4  
ID 5  
NUMBER 6  
P AUTH 7  
TPL INJURY 8  
CODE 9  
SFL ZIP: 29138  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY 310.9  
SECONDARY

10 RECIPIENT NAME - KEITH E MURPHY  
11 DATE OF BIRTH 09/04/1964 12 SEX M

13 RES 14 ALLOWED LN NO 15 DATE OF SERVICE 16 PLACE 17 PROC 18 MOD  
19 INDIVIDUAL CHARGE 20 PAY UNITS 21 22  
23 NDC

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

\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

1 NPI: 1861472490 2 TAXONOMY: 31 T1015 000 RHC022 73.89 1.000

INS CARR NUMBER 24  
NPI: 8  
TAXONOMY: 25  
POLICY NUMBER 26  
INS CARR PAID  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 107207146

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
INSURANCE POLICY INFORMATION

P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

*McLind. unsubmitted*

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

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DIAGNOSIS  
PRIMARY  
SECONDARY  
310.9

RUN DATE 06/19/2007 000024850  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
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3 SFL ZIP: 29138  
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PROVIDER  
RECIPIENT  
P AUTH TPL INJURY EMERG PC COORD  
ID  
RHCO22 4780106128  
NP1: 1104970847

10 RECIPIENT NAME - STEVEN R HIPP

11 DATE OF BIRTH 08/25/1959 12 SEX M

13 RES 14 ALLOWED LN NO 15 DATE OF SERVICE 16 PLACE 17 PROC 18 MOD 19 INDIVIDUAL CHARGE 20 PAY UNITS 21 22 AGENCY USE ONLY 23 APPROVED EDITS 24 REJECTED LINE EDITS 25 \*\*\*\*\*

\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

RHCO22 73.89 1.000

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NDC

NP1: 1861472490 1 .00 05/07/07 31 T1015 000

TAXONOMY: 2

NP1: 1861472490 2

TAXONOMY: 3

TAXONOMY: 4

TAXONOMY: 5

TAXONOMY: 6

TAXONOMY: 7

TAXONOMY: 8

TAXONOMY: 25

TAXONOMY: 26

INS CARR NUMBER 24  
POLICY NUMBER 25  
PAID 26

01 620 249195825A 58.20  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 98783

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SC 29138-0248  
SALUDA

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

*mc/mo unsubmitted*

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
04) 721

--- DIAGNOSIS ---  
8  
PRIMARY SECONDARY  
491.21 786.50

REPORT NUMBER CLM3500  
ANALYST ID PROJ2  
SIGNON ID CBRN  
TAXONOMY:  
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3 SFL ZIP: 29138  
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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

01) 977

11 DATE OF BIRTH 04/09/1936 12 SEX M

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

73.89 1.000

\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

RUN DATE 06/26/2007 000025092  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
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PROVIDER  
RECIPIENT  
ID  
ID  
RHC022 3780427501  
NPI: 1104970847

SFL ZIP: 29138  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY  
SECONDARY  
680.2

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

10 RECIPIENT NAME - ROBERT E LONGSHORE

23  
NDC

RHC022

05/03/07 31 T1015 000

NPI: 1861472490

TAXONOMY:

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TAXONOMY:

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INS CAR

PAID

58.20

250469305A

01 620

INS CAR  
NUMBER

NPI:

NPI:

NPI:

NPI:

NPI:

NPI:

NPI:

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:

MEDICAID CLAIMS RECEIPT

P. O. BOX 1412

COLUMBIA, S.C. 29202-1412

PROVIDER:

RILEY FAMILY PRACTICE ASSO

PO BOX 248

SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 06/26/2007 000025091  
REPORT NUMBER CLM3500

ANALYST ID  
SIGNON ID  
TAXONOMY:  
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PROVIDER  
RECIPIENT  
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TPL  
INJURY  
EMERG  
PC COORD  
PRV ZIP: 29138  
SFL ZIP: 29138  
DIAGNOSIS  
PRIMARY  
SECONDARY  
HIC - 22 PRAC SPEC - 97  
DOC IND N

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

10 RECIPIENT NAME - BEATRICE JUSTICE

11 DATE OF BIRTH 08/27/1916 12 SEX F

13	RES	14	ALLOWED	LN	DATE OF	15	SERVICE	16	PLACE	17	PROC	18	MOD	19	INDIVIDUAL	20	CHARGE	21	PAY	22	UNITS
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23	NDC	20	73.89	RHC022	1.000	000	05/02/07	31	T1015	000	000	000	000	000	000	000	000	000	000	000	000
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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
\*\*\*\*\*  
EDIT  
PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
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24	INS CARR	25	POLICY	26	INS CARR	27	TOTAL CHARGE	28	AMT REC'D INS	29	BALANCE DUE	30	OWN REF #	31	519139
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RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

mc/mvd

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

01) 977

11 DATE OF BIRTH 11/10/1910 12 SEX F

DOC IND N  
HIC - 22 PRAC SPEC - 97  
EDIT CORRECTION FORM  
SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRV ZIP: 29138

SFL ZIP: 29835  
3 AUTH TPL INJURY EMERG PC COORD  
NUMBER CODE

REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 ID  
4 RHC022 2074542501  
NPI: 1104970847

10 RECIPIENT NAME - LILLIAN S HUDSON

13 RES  
14 ALLOWED  
15 LN  
16 DATE OF SERVICE  
17 PLACE  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
21 APPROVED EDITS  
22 REJECTED LINE EDITS  
23 NDC  
24 TAXONOMY:  
25 NPI: 1861472490  
26 TAXONOMY:  
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73.89 1.000

RHC022

000 T1015

04/03/07 31

1.00 NPI: 1861472490

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ADDITIONAL DIAG CODES:

RESOLUTION DECISION

03

02

01 620

PD266542124

58.20

28 AMT REC'D INS

58.20

27 TOTAL CHARGE

73.89

29 BALANCE DUE

15.69

30 OWN REF #

17677

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

mccl m.d.  
unsubmitted

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS

LINE EDITS  
(01) 977

11	DATE OF BIRTH	03/30/1946	12	SEX	F
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19	20	21	22
INDIVIDUAL CHARGE	PAY	UNITS	
PROVIDER	IND		

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** REJECTED LINE EDITS **
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1.00	1	05/01/07	31	T1015	000	RHC022	73.89	1.000
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25 POLICY NUMBER  
26 INS CARR PAID

RESOLUTION DECISION \_\_\_\_\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAL CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

**SALUDA** **SC 29138-0248**

**PO BOX 248**

**PROVIDER:**  
**RILEY FAMILY PRACTICE ASSO**

P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

**MEDICAL**

inc/mo submitted  
RAC



ORIGINAL CCN:  
ADJ CCN:  
EDITS  
INSURANCE EDITS  
00-401  
CLAIM EDITS

**LINE EDITS**

[illegible]

MC/mo  
only

RUN DATE 06/26/2007 000025099  
 REPORT NUMBER CLM3500  
 ANALYST ID  
 SIGNON ID  
 TAXONOMY:  
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 PROVIDER  
 2  
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 SFL  
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 AU  
 NUMB  
 ID  
 RHC022 4729106601  
 NPI: 1104970847

D HUMAN SERVICES  
 FORM  
 EC - 97  
 DOC IND N  
 8  
 --- DIAGNOSIS ---  
 PRIMARY  
 401.1  
 SECONDARY  
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10	RECIPIENT NAME - JOHN	HILL	11	DATE OF BIRTH	07/19/1927	12	SEX	M
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13	RES	14	ALLOWED	NO	LN	DATE OF	SERVICE	15	16	PLACE	17	PROC	CODE	18	MOD
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NDC

1.00	1	05/08/07	31	T1015	000	RHC022	73.89	1.000
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NP1: 2 TAXONOMY:

NP 1 : TAXONOMY: 4

NP1: 5 / / TAXONOMY:

NP I : TAXONOMY:

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**POLICY NUMBER**

25 POLICY NUMBER  
26 INS CARR PAID

25 1382075A 58.21

27	TOTAL CHARGE	73.89
28	AMT REC'D INS	58.20
29	BALANCE DUE	15.69
30	OWN REF #	889759

RESOLUTION DECISION \_\_\_\_\_

ADDITIONAL DIAG CODES:

## INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PO BOX 248  
SALUDA SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

ANALYST ID  
SIGNON ID  
TAXONOMY:  
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PROVIDER  
ID  
RHC022  
NPI : 1104970847  
6411350201

LINE EDITS

11 DATE OF BIRTH	10/29/1925	12 SEX	M
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10 RECIPIENT NAME - ROY

[illegible]

	PAYMENT DATE	EDIT
	CLAIMS/LINE PAYMENT INFO	

23  
NDC[illegible][illegible]

RESOLUTION DECISION \_\_\_\_\_

ADDITIONAL DIAG CODES:

## INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA SC 29

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
00-150  
CLAIM EDITS  
LINE EDITS  
01) 977

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19 INDIVIDUAL CHARGE  
20 PAY UNITS  
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mc/MD  
unsubmitted

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
X1R CUM110876464001B  
PATTERSON  
BETTY  
INSURANCE POLICY INFORMATION

PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248  
\* PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED \*  
\* INDICATES A SPLIT CLAIM

RESOLUTION DECISION  
03  
02  
01 620 251463507A  
24 INS CAR NUMBER  
25 POLICY NUMBER  
26 INS CAR PAID  
27 TOTAL CHARGE  
28 AMT REC'D INS  
29 BALANCE DUE  
30 OWN REF # 141426

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29138  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY  
SECONDARY  
812.20  
TAXONOMY:  
SIGNON ID  
ANALYST ID  
REPORT NUMBER CLM3500  
RUN DATE 06/26/2007 000025115

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

--- DIAGNOSIS ---  
8  
PRIMARY  
401.1  
SECONDARY

ANALYST ID  
SIGNON ID  
TAXONOMY:  
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PROVIDER  
2  
RECIPIENT  
3  
P AUTH  
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TPL  
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INJURY  
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EMERG  
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PC COORD  
8  
SFL ZIP: 29138  
PRV ZIP: 29138

10 RECIPIENT NAME - MYRTIS DORN

11 DATE OF BIRTH 11/16/1931 12 SEX F

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

1 00 05/08/07 31 T1015 000 RHCO22 73.89 1.000

NPI: 1861472490 TAXONOMY:

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ADDITIONAL DIAG CODES:

RESOLUTION DECISION

01 620 249508806M 58.20 27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 9872263

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

mc/mjd  
unsubmitted



SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

**DOC IND N**

6 S I S O N J V I Q 8

**PRIMARY**

01/ 977 715 932 977  
02) 715 932 977

11 DATE OF BIRTH	07/01/1917	12 SEX	F	01/977	02) 715 932 977
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# EDIT                                #
# PAYMENT DATE                       #
# CLAIMS/LINE PAYMENT INFO          #
#####

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me/mo  
canceled

**INSURANCE POLICY INFORMATION**

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED" # INDICATES A SPLIT CLAIM

SC 29138-0248



SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29835  
PRV ZIP: 29138  
TAXONOMY:  
1 ANALYST ID  
2 SIGNON ID  
3 PROVIDER  
4 RECIPIENT  
5 P AUTH TPL INJURY CODE  
6 EMERG PC COORD  
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LINE EDITS  
CLAIM EDITS  
INSURANCE EDITS  
ADJ GCN:  
ORIGINAL GCN:  
EMC  
REJECTED LINE EDITS  
AGENCY USE ONLY  
APPROVED EDITS  
NDC  
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10 RECIPIENT NAME - MATTIE H ELLIOTT  
11 DATE OF BIRTH 03/26/1914 12 SEX F  
13  
14 ALLOWED  
15 DATE OF SERVICE  
16 PLACE  
17 PROC  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS  
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24	25	26	27	28	29	30	31
01 620	250012415A	58.20	73.89	104644133			
02							
03							

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/01/2007 000021926

REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 P AUTH  
4 TPL INJURY  
5 EMERG PC COORD  
6 PRV ZIP: 29138  
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--- DIAGNOSIS ---  
PRIMARY SECONDARY  
401.1

ORIGINAL CGN:  
ADJ CGN:  
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INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

01) 977

10 RECIPIENT NAME - JOSIE B PHILLIPS 11 DATE OF BIRTH 12/17/1916 12 SEX F

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

23 NDC

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AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
EDIT  
\*\*\*\*\*

1 NPI: 1861472490 2 TAXONOMY: 3 05/18/07 31 T1015 000 RHCO22 73.89 1.000

1 NPI: 1861472490 2 TAXONOMY: 3 05/18/07 31 T1015 000 RHCO22 73.89 1.000

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1 NPI: 1861472490 2 TAXONOMY: 3 05/18/07 31 T1015 000 RHCO22 73.89 1.000

ADDITIONAL DIAG CODES:

RESOLUTION DECISION

03 01 620 158074937D 27 TOTAL CHARGE 73.89  
29 BALANCE DUE 15.69  
30 OWN REF # 82368

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

8	9
--- DIAGNOSIS ---	---
PRIMARY	SECONDARY
290.0	

**CLAIM EDITS**

## LINE EDITS

11	DATE OF BIRTH	03/26/1914	12	SEX	F
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19	20	21	22
INDIVIDUAL	CHARGE	PAY	UNITS
PROVIDER	IND		

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** AGENCY USE ONLY **  
** APPROVED EDITS **  
** REJECTED LINE EDITS **  
*****  
*****  
***** CLAIMS/LINE PAYMENT INFO *****  
***** EDIT PAYMENT DATE *****
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00	1	05/16/07	31	T1015	000	RHC022	73.89	1.000
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INS CARR NUMBER	24	25	POLICY NUMBER	26	INS CARR PAID
NP I : 1861472490	1	2	1	TAXONOMY: / /	31
NP I :	00	3	2	TAXONOMY: / /	05/16/07
NP I :		4	3	TAXONOMY: / /	
NP I :		5	4	TAXONOMY: / /	
NP I :		6	5	TAXONOMY: / /	
NP I :		7	6	TAXONOMY: / /	
NP I :		8	7	TAXONOMY: / /	
NP I :				TAXONOMY: / /	

	NUMBER	NUMBER	PAID	27 TOTAL CHARGE	73.89
01	620	250012415A	58.20	28 AMT REC'D INS	58.20
02				29 BALANCE DUE	15.69
03				30 OWN REF #	104644134

**ADDITIONAL DIAG CODES:**

RETURN TO: INSURANCE POLICY INFORMATION

P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

**PROVIDER:**  
**RILEY FAMILY PRACTICE ASSO**

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
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RUN DATE 07/01/2007 000021918  
SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29835  
PRV ZIP: 29138  
6  
EMERG PC COORD  
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PROVIDER  
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RECIPIENT  
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P AUTH TPL INJURY CODE  
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NUMBER  
13  
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RHCO22 1922521401  
NPI: 1104970847  
10 RECIPIENT NAME - ROBERT  
SIBERT  
11 DATE OF BIRTH 06/21/1929 12 SEX M  
13  
14  
ALLOWED  
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DATE OF  
16  
PLACE  
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AGENCY USE ONLY  
23  
REJECTED LINE EDITS  
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13 RES  
14 ALLOWED  
15 NO  
16 SERVICE  
17 DATE OF  
18 PLACE  
19 PROC  
20 MOD  
21 IND  
22 PROVIDER  
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RHCO22 73.89  
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01 620 250469081A 58.20  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 87880

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

TAXONOMY: 1  
PROVIDER 2  
RECIPIENT 3  
P AUTH 4  
TPL INJURY 5  
EMERG PC COORD 6  
PRV ZIP: 29138 7  
DIAGNOSIS 8  
PRIMARY SECONDARY 9  
RHC022 7230310201  
ID ID  
NPI: 1104970847

ORIGINAL CGN:  
ADJ CGN:  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

10 RECIPIENT NAME - JIMMY L JONES 11 DATE OF BIRTH 01/22/1936 12 SEX M

13	RES	14	ALLOWED	LN	NO	15	DATE OF SERVICE	16	PLACE	17	PROC	18	MOD	19	INDIVIDUAL CHARGE	20	21	22	PAY UNITS	23	MDC

24	INS CARR NUMBER	25	POLICY NUMBER	26	INS CARR PAID	27	TOTAL CHARGE	28	AMT REC'D INS	29	BALANCE DUE	30	OWN REF #	31	1015	000	RHC022	73.89	1.000

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
\*\*\*\*\*  
EDIT PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
\*\*\*\*\*

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

ANALYST ID  
SIGNON ID  
TAXONOMY:  
1  
PROVIDER  
ID  
RHC022 924356701  
NPI : 1104970847

10 RECIPIENT NAME - BEATRICE JUSTICE

NP 1 : 1861472490  
1 00

INS CARR NUMBER	INS CARR NUMBER	INS CARR NUMBER
24	25	26
NP1:	8	TAXONOMY:
NP1:	7	TAXONOMY:
NP1:	6	TAXONOMY:
NP1:	5	TAXONOMY:
NP1:	4	TAXONOMY:
NP1:	3	TAXONOMY:
NP1:	2	TAXONOMY:
NP1: 1861472490	1	01/02/07
.00		31
		11015

## RESOLUTION DECISION

**ADDITIONAL DIAG CODES:**

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED" \* INDICATES A SPLIT CLAIM

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/01/2007 000021931  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

TAXONOMY: 1  
PROVIDER ID 2  
RECIPIENT ID 3  
P AUTH 4  
INJURY 5  
EMERG 6  
PC COORD 7  
PRV ZIP: 29138 8  
DOC IND N 9  
DIAGNOSIS  
PRIMARY 465.9  
SECONDARY

EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS

01) 977

10 RECIPIENT NAME - BEATRICE JUSTICE 11 DATE OF BIRTH 08/27/1916 12 SEX F

13 RES 14 ALLOWED 15 DATE OF SERVICE 16 PLACE 17 PROC 18 MOD 19 INDIVIDUAL CHARGE 20 PAY UNITS 21 22 AGENCY USE ONLY 23 REJECTED LINE EDITS  
13 14 15 16 17 18 19 20 21 22 23  
RES ALLOWED LN NO DATE OF SERVICE PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS AGENCY USE ONLY REJECTED LINE EDITS  
13 14 15 16 17 18 19 20 21 22 23  
RES ALLOWED LN NO DATE OF SERVICE PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS AGENCY USE ONLY REJECTED LINE EDITS

1.000  
RHC022 73.89  
EDITS  
CLAIMS/LINE PAYMENT INFO  
PAYMENT DATE

INS CARR NUMBER 24  
INS CARR NUMBER 25  
POLICY NUMBER 26  
TAXONOMY: 27  
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01 620 402304843B 28 AMT REC'D INS 29 BALANCE DUE 30 OWN REF # 519131  
27 TOTAL CHARGE 73.89  
26 INS CARR PAID 73.89  
25 POLICY NUMBER 73.89  
24 INS CARR NUMBER 73.89  
23 TAXONOMY: 73.89  
22 TAXONOMY: 73.89  
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1 TAXONOMY: 73.89

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO: MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER: RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

ORIGINAL CGN: EMC  
ADJ CGN: EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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\*\*\*\*\*  
PAYMENT DATE  
CLAIMS/LINE PAYMENT INFO  
\*\*\*\*\*

RUN DATE 07/01/2007 000021946  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 AUTH TPL INJURY CODE  
4 SFL ZIP: 29835  
5  
6 EMERG PC COORD  
7  
8  
9  
10 RECIPIENT NAME - MYRTIS ADAMS  
11 DATE OF BIRTH 09/23/1929 12 SEX F  
13  
14 ALLOWED LN NO  
15 DATE OF SERVICE  
16 PLACE  
17 PROC MOD  
18  
19 INDIVIDUAL CHARGE IND  
20  
21 PAY UNITS  
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13	RES	14	ALLOWED	LN	NO	15	DATE OF	16	PLACE	17	PROC	18	MOD	19	INDIVIDUAL	20	CHARGE	21	PAY	22	UNITS	23	NDC	24	INS CARR	25	POLICY	26	INS CARR	27	TOTAL CHARGE	28	AMT REC'D INS	29	BALANCE DUE	30	OWN REF #																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																
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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/01/2007 000021930  
REPORT NUMBER CLM3500

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29138  
PRV ZIP: 29138  
EMERG PC COORD  
DIAGNOSIS  
PRIMARY SECONDARY  
332.0  
RHC022 3780427501  
NPI: 1104970847

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 977

10 RECIPIENT NAME - ROBERT E LONGSHORE

13 RES 14 ALLOWED LN NO DATE OF SERVICE PLACE PROC MOD  
18 17 16 15 14 13  
19 INDIVIDUAL CHARGE PAY UNITS  
20 21 22  
23 NDC

11 DATE OF BIRTH 04/09/1936 12 SEX M  
RHCO22 73.89 1.000

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

INS CARR NUMBER 24  
INS CARR NUMBER 25  
POLICY NUMBER 26  
INS CARR PAID  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 131433

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021930  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER ID  
2 RECIPIENT ID  
3 RHC022  
4 3780427501  
5 NPI: 1104970847

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

CLAIM CONTROL #0717101576003400A  
PAGE 18937 ECF 18937 PAGE 1 OF 1  
EMC  
ORIGINAL CCN:  
ADJ CCN:

EDITS  
INSURANCE EDITS

CLAIM EDITS

LINE EDITS  
01) 977

10 RECIPIENT NAME - ROBERT E LONGSHORE

11 DATE OF BIRTH 04/09/1936 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

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

.00 1 05/15/07 31 T1015 000  
NPI: 1861472490 TAXONOMY:  
2 / /  
NPI: TAXONOMY:  
3 / /  
NPI: TAXONOMY:  
4 / /  
NPI: TAXONOMY:  
5 / /  
NPI: TAXONOMY:  
6 / /  
NPI: TAXONOMY:  
7 / /  
NPI: TAXONOMY:  
8 / /  
NPI: TAXONOMY:

23  
NDC

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
!  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID  
01 620 250469305A 58.20  
02  
03

27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 131433

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021929

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 PROVIDER ID  
2 RECIPIENT ID  
RHC022 4780352323  
NPI: 1104970847

SFL ZIP: 29835

3 P AUTH NUMBER  
4 TPL  
5 INJURY CODE

PRV ZIP: 29138

6 EMERG  
7 PC COORD

8 ---- DIAGNOSIS ----  
PRIMARY SECONDARY  
429.2

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 22 PRAC SPEC - 97

DOC IND N

CLAIM CONTROL #0717101573003400A

PAGE 18936 ECF 18936 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 977

10 RECIPIENT NAME - MARTHA V KEITH

11 DATE OF BIRTH 08/04/1934 12 SEX F

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  
100 1 05/18/07 31 T1015 000 RHC022 73.89 1.000  
NPI: 1861472490 TAXONOMY:  
2 / /  
NPI: TAXONOMY:  
3 / /  
NPI: TAXONOMY:  
4 / /  
NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
7 / /  
NPI: TAXONOMY:  
8 / /  
NPI: TAXONOMY:

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

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID  
01 620 249486436A 58.20  
02  
03

27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 124642

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

INSURANCE POLICY INFORMATION

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021928  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER ID RHC022  
2 RECIPIENT ID 1244655501  
NPI: 1104970847

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

CLAIM CONTROL #0717101572003400A  
PAGE 18935 ECF 18935 PAGE 1 OF 1  
EMC  
ORIGINAL CCN:  
ADJ CCN:  
EDITS  
INSURANCE EDITS  
00-150

SFL ZIP: 29835 PRV ZIP: 29138  
3 P AUTH INJURY EMERG PC COORD  
4 TPL INJURY CODE  
5 INJURY CODE  
6 EMERG  
7 PC COORD  
8 DIAGNOSIS  
9 PRIMARY SECONDARY  
787.03

CLAIM EDITS

10 RECIPIENT NAME - GERALDINE MCDUFFIE

11 DATE OF BIRTH 09/25/1947 12 SEX F

LINE EDITS  
01) 977

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	11/29/06	31	T1015	000	RHC022	73.89		1.000
	NPI: 1861472490	2	TAXONOMY:							
	NPI:	3	TAXONOMY:							
	NPI:	4	TAXONOMY:							
	NPI:	5	TAXONOMY:							
	NPI:	6	TAXONOMY:							
	NPI:	7	TAXONOMY:							
	NPI:	8	TAXONOMY:							
	NPI:		TAXONOMY:							
24 INS CARR NUMBER		25 POLICY NUMBER		26 INS CARR PAID						
01 620	249924437A			63.60						
02										
03										

\*\*\*\*\*  
\*\* AGENCY USE ONLY \*\*  
\*\* APPROVED EDITS \*\*  
\*\* REJECTED LINE EDITS \*\*  
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!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 63.60  
29 BALANCE DUE 10.29  
30 OWN REF # 14798

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION  
400 249924437  
MCDUFFIE GERALDINE

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021927  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

CLAIM CONTROL #0717101569003400A  
PAGE 18934 ECF 18934 PAGE 1 OF 1  
EMC  
ORIGINAL CCN:  
ADJ CCN:

TAXONOMY: SFL ZIP: 29835 PRV ZIP: 29138  
1 2 3 4 5 6 7 8 9  
PROVIDER RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----  
ID ID NUMBER CODE PRIMARY SECONDARY  
RHC022 7334889401  
NPI: 1104970847  
294.11

EDITS  
INSURANCE EDITS

CLAIM EDITS

LINE EDITS  
01) 977

10 RECIPIENT NAME - SAMUEL J POWELL 11 DATE OF BIRTH 06/16/1934 12 SEX M  
13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL CHARGE 20 PAY UNITS 21 22  
NDC

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

.00 1 05/09/07 31 T1015 000 RHC022 73.89 1.000  
NPI: 1861472490 TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:

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! CLAIMS/LINE PAYMENT INFO !  
!  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER PAID  
01 620 252487599A 58.20  
02  
03  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 145725

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021960  
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

CLAIM CONTROL #0717206559018700A  
PAGE 18967 ECF 18967 PAGE 1 OF 1

ANALYST ID  
SIGNON ID

DOC IND N

TAXONOMY:

SFL ZIP: 29138

PRV ZIP: 29138

1 PROVIDER ID  
2 RECIPIENT ID  
RHC022 3780427501  
NPI: 1104970847

3 P AUTH NUMBER  
4 TPL  
5 INJURY CODE

6 EMERG  
7 PC COORD

8 ---- DIAGNOSIS ----  
9 PRIMARY SECONDARY  
332.0

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS  
02-733

CLAIM EDITS

LINE EDITS

01) 977

10 RECIPIENT NAME - ROBERT

E LONGSHORE

11 DATE OF BIRTH 04/09/1936

12 SEX M

13 RES

14 ALLOWED

15 LN NO

16 DATE OF SERVICE

17 PLACE

18 PROC CODE

19 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: 1861472490

04/17/07 31  
TAXONOMY:

T1015

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RHC022

73.89

1.000

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TAXONOMY:

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NPI:

/ /  
TAXONOMY:

24  
INS CARR  
NUMBER

25  
POLICY  
NUMBER

26  
INS CARR  
PAID

27 TOTAL CHARGE 73.89

01 620 250469305A

58.20

28 AMT REC'D INS 58.20

02 139 250469305

.00

29 BALANCE DUE 15.69

03

30 OWN REF # 131431

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/01/2007 000021945  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

CLAIM CONTROL #0717102547005600A  
PAGE 18952 ECF 18952 PAGE 1 OF 1  
EMC  
ORIGINAL CCN:  
ADJ CCN:

TAXONOMY: SFL ZIP: 29138 PRV ZIP: 29138  
1 2 3 4 5 6 7 8 9  
PROVIDER RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----  
ID ID NUMBER CODE PRIMARY SECONDARY  
RHC022 2410517501  
NPI: 1104970847 401.1

EDITS  
INSURANCE EDITS

CLAIM EDITS

LINE EDITS  
01) 977

10 RECIPIENT NAME - LUDIE C BROWN 11 DATE OF BIRTH 06/06/1919 12 SEX F  
13 14 15 16 17 18 19 20 21 22  
RES ALLOWED LN DATE OF SERVICE PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS  
NO  
23  
NDC  
1 05/15/07 31 T1015 000 RHC022 73.89 1.000  
NPI: 1861472490 TAXONOMY:  
2 / /  
NPI: TAXONOMY:  
3 / /  
NPI: TAXONOMY:  
4 / /  
NPI: TAXONOMY:  
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NPI: TAXONOMY:  
6 / /  
NPI: TAXONOMY:  
7 / /  
NPI: TAXONOMY:  
8 / /  
NPI: TAXONOMY:  
24 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER PAID  
01 620 251368333M 58.20  
02  
03  
27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 10188765

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

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA SC 29138-0248

INSURANCE POLICY INFORMATION

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
00-690

CLAIM EDITS

LINE EDITS

01) 977

\*\*\*\*\*  
AGENCY USE ONLY  
APPROVED EDITS  
REJECTED LINE EDITS  
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\*\*\*\*\*  
1.000  
\*\*\*\*\*

\*\*\*\*\*  
CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE  
\*\*\*\*\*

11 DATE OF BIRTH 02/19/1915 12 SEX F

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

RHC022 73.89 000

NP1: 1861472490  
TAXONOMY: 2  
TAXONOMY: 3  
TAXONOMY: 4  
TAXONOMY: 5  
TAXONOMY: 6  
TAXONOMY: 7  
TAXONOMY: 8  
TAXONOMY: 25  
INS POLICY NUMBER 26

05/08/07 31 T1015 000

23 MDC

27 TOTAL CHARGE 73.89

28 AMT REC'D INS 73.60

29 BALANCE DUE .29

30 OWN REF # 90773

INSURANCE POLICY INFORMATION

RUN DATE 07/24/2007 000021893  
SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N  
SFL ZIP: 29138  
PRV ZIP: 29138  
5 INJURY CODE  
6 EMERG PC COORD  
7  
8  
9  
10 ANALYST ID  
11 SIGNON ID  
12 TAXONOMY:  
13 PROVIDER  
14 RECIPIENT  
15 P AUTH  
16 TPL  
17 NUMBER  
18 ID  
19 RHC022 141513901  
NP1: 1104970847

10 RECIPIENT NAME - THELMA J KNOX

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

RHC022 73.89 000

NP1: 1861472490  
TAXONOMY: 2  
TAXONOMY: 3  
TAXONOMY: 4  
TAXONOMY: 5  
TAXONOMY: 6  
TAXONOMY: 7  
TAXONOMY: 8  
TAXONOMY: 25  
INS POLICY NUMBER 26

05/08/07 31 T1015 000

23 MDC

27 TOTAL CHARGE 73.89

28 AMT REC'D INS 73.60

29 BALANCE DUE .29

30 OWN REF # 90773

ADDITIONAL DIAG CODES:

RESOLUTION DECISION

03

02

01 620 248032346A

INS CARR NUMBER 24  
NP1: 248032346A

NP1: 248032346A

NP1: 248032346A

NP1: 248032346A

NP1: 248032346A

NP1: 248032346A

NP1: 248032346A

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NP1: 248032346A

NP1: 248032346A

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P.O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
# INDICATES A SPLIT CLAIM



SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY: 1  
PROVIDER 2  
ID 3  
ID 4  
ID 5  
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ID 11  
ID 12  
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10 RECIPIENT NAME - IDESSA  
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13 RES  
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01 620 069902575141 27 TOTAL CHARGE 73.89  
28 ANT REC'D INS 67.64  
29 BALANCE DUE 6.25  
30 OWN REF # 943880  
02  
03

RESOLUTION DECISION  
ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248  
SALUDA

SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

EMC  
ORIGINAL CGN:  
ADJ CGN:  
EDITS  
INSURANCE EDITS  
00-150

13	RES	14	ALLOWED	LN	DATE OF	15	PLACE	16	PROC	17	MOD	18	INDIVIDUAL	19	CHAR	20
10	RECIPIENT NAME - BETTY						H PATERSON			11	DATE OF BIRTH	05/28/1930				

	CLAIMS/LINE PAYMENT INFO	EDIT	PAYMENT DATE
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27	TOTAL CHARGE	73.89
28	AMT REC'D INS	58.20
29	BALANCE DUE	15.69
30	OWN REF #	141427

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
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ORIGINAL CGN:  
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REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 PROVIDER  
2 RECIPIENT  
3 P AUTH  
4 TPL INJURY  
5 CODE  
6 EMERG PC COORD  
7 PRV ZIP: 29138  
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10 RECIPIENT NAME - KEITH E MURPHY 11 DATE OF BIRTH 09/04/1964 12 SEX M

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

23 NDC 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100

1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200

CLAIM CONTROL #0718703271006800A  
PAGE 19680 ECF 19680 PAGE 1 OF 1

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

**DOC END N**

SFL ZIP: 29138  
PRV ZIP: 29138

3	4	5	6	7	8	9
P AUTH	TPL	INJURY	ENERG	PC COORD	DIAGNOSIS	PRIMARY SECONDARY

**PRIMARY**

## CLAIM EDITS

776 (10

11	DATE OF BIRTH	08/27/1916	12	SEX	F
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LN	DATE OF	PLACE	PROC	MOD
15	16	17	18	

19	20	21	22	INDIVIDUAL CHARGE	PAY	UNITS
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NP1 : 1861472490

**TAXONOMY:**

**TAXONOMY:**

**TAXONOMY:**

**TAXONOMY.**

11/11

ARCHIVE 11

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25  
POLICY  
NUMBER

4023048438

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27	TOTAL CHARGE	73.89
28	AMT REC'D INS	58.20
29	BALANCE DUE	15.69
30	OWN REF #	519140

**ADDITIONAL DIAG CODES:**

P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/24/2007 000021881

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

PROVIDER ID  
ID  
ID  
RHCO22 3780087336  
NPI: 1104970847

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97  
DOC IND N

SFL ZIP: 29138

PRV ZIP: 29138

PROVIDER PC COORD  
EMERG 6  
INJURY 5  
TPL 4  
AUTH 3  
NUMBER 2

DIAGNOSIS  
PRIMARY 8  
SECONDARY 9

CLAIM EDITS

INSURANCE EDITS

ADJ CGN:

ORIGINAL CGN:

EMC

CLAIM CONTROL #0718703264006800A  
PAGE 19679 ECF 19679 PAGE 1 OF 1

10 RECIPIENT NAME - LILLIAN B COCKRELL

11 DATE OF BIRTH 09/26/1920

12 SEX F

13 RES  
14 ALLOWED  
15 LN  
16 DATE OF  
17 PLACE  
18 MOD  
19 INDIVIDUAL CHARGE  
20 PAY UNITS

21 22  
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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RUN DATE 07/24/2007 000021880  
REPORT NUMBER CLM3500

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

DOC IND N

PRV ZIP: 29138

SFL ZIP: 29138

1 ANALYST ID  
2 PROVIDER  
3 AUTH TPL INJURY  
4 EMERG PC COORD  
5 DIAGNOSIS  
6 PRIMARY SECONDARY  
7 ID  
8 RHC022 9780167723  
9 NPI: 1104970847

10 RECIPIENT NAME - BETTE

11 DATE OF BIRTH 03/30/1946 12 SEX F

13 RES

14 ALLOWED LN

15 DATE OF SERVICE

16 PLACE

17 PROC CODE

18 MOD

19 INDIVIDUAL CHARGE

20 PAY UNITS

21 AGENCY USE ONLY

22 APPROVED EDITS

23 REJECTED LINE EDITS

24 RHC022

73.89

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CLAIMS/LINE PAYMENT INFO  
EDIT  
PAYMENT DATE

C COURTNEY

05/28/07

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73.89

1.000

NPI: 1861472490

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TAXONOMY:

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TAXONOMY:

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POLICY NUMBER

INS CAR

PAID

175366869A

58.20

27 TOTAL CHARGE 73.89  
28 AMT REC'D INS 58.20  
29 BALANCE DUE 15.69  
30 OWN REF # 131655

ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

PROVIDER:  
RILEY FAMILY PRACTICE ASSO

PO BOX 248

SC 29138-0248

SALUDA

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM

RUN DATE 07/24/2007 000021879

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

2 PROVIDER

4410492901 ID

RHC022 ID

NP1: 1104970847

10 RECIPIENT NAME - MYRTIS

DORN

11 DATE OF BIRTH 11/16/1931

12 SEX F

LINE EDITS

CLAIM EDITS

INSURANCE EDITS

EDITS

ADJ CN:

ORIGINAL CN:

ENC

PAGE 19677 ECF 19677 PAGE 1 OF 1

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 22 PRAC SPEC - 97

DOC IND N

PRV ZIP: 29138

6 EMERG PC COORD

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DIAGNOSIS

PRIMARY SECONDARY

311.

13 RES

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SERVICE

16 PLACE

PROC

MOD

23

NDC

19 INDIVIDUAL CHARGE

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21 22

UNITS

AGENCY USE ONLY

APPROVED EDITS

REJECTED LINE EDITS

11 CLAIMS/LINE PAYMENT INFO

12 EDIT

13 PAYMENT DATE

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SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM  
HIC - 22 PRAC SPEC - 97

DOC IND N

ORIGINAL CGN:  
ADJ CGN:

EDITS  
INSURANCE EDITS

00-151

CLAIM EDITS

LINE EDITS

11 DATE OF BIRTH 02/19/1915 12 SEX F 01) 977

10 RECIPIENT NAME - THELMA J KNOX

13	RES	14	ALLOWED	LN	DATE OF	15	SERVICE	16	PLAC	17	PROC	18	MOD	19	INDIVIDUAL CHARGE	20	PAY UNITS	21	22	23	NDC

1	00	03/13/07	31	T1015	000	RHC022	72.75	1.000
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NP1: 1861472490	2	TAXONOMY:	3	TAXONOMY:	4	TAXONOMY:	5	TAXONOMY:	6	TAXONOMY:	7	TAXONOMY:	8	TAXONOMY:	25	POLICY	26	INS CAR	PAID
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01 620	248032346A	58.20	28	AMT REC'D INS	69.60	27	TOTAL CHARGE	72.75
02 469	169592291	11.40	29	BALANCE DUE	3.15	30	OWN REF #	90771

RESOLUTION DECISION \_R\_

ADDITIONAL DIAG CODES:

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P.O. BOX 1412  
COLUMBIA, S.C. 29202-1412  
PROVIDER:  
RILEY FAMILY PRACTICE ASSO  
PO BOX 248  
SALUDA  
SC 29138-0248

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM



# State of South Carolina

## Department of Health and Human Services

Mark Sanford  
Governor

Emma Forkner  
Director

August 24, 2007

Ralph N. Riley, M.D.  
Riley Family Practice Associates, PA  
Post Office Box 248  
595 Newberry Highway  
Saluda, South Carolina 29138

Dear Dr. Riley:

Thank you for the recent letter requesting an exception from the 977 edit code for patients residing in a skilled nursing facility. We welcome the opportunity to be of assistance.

The South Carolina Department of Health and Human Services (SCDHHS) Nursing Home policy requires that patients receive one evaluation examination every thirty days. The policy also requires documentation be attached to all claims over the twelve allowed ambulatory visits per fiscal year substantiating medical necessity. Upon receipt of the claim with the attached documentation, the claim will be reviewed and, if applicable, paid.

SCDHHS is currently analyzing the possibility of creating an exception to the ambulatory visits policy for patients residing in nursing homes. If the decision is made to update the current policy, a bulletin will be distributed advising all providers of the effective date of the change.

The Edit Correction Forms enclosed with your letter have been forwarded to your Program Coordinator, Clarissa Johnson, for processing.

We appreciate your taking the time to contact us and for your continued support and participation in the South Carolina Medicaid program. If you have any questions or if we can be of further assistance, please contact Ms. Valeria Williams, Division Director for Physician Services, at (803) 898-3477.

Sincerely,

Melanie "BZ" Giese, RN  
Bureau Director for Health Services

MG/wd

#59  
✓