

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Supra</i>	DATE <i>7-17-12</i>
--------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000021</i>	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE <i>7-25-12</i>
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Keck, Singleton, Keck</i> <i>Closed 7/19/12, see attached</i> <i>e-mail response.</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <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.			

***JOE WILSON**

2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:

ARMED SERVICES

RANKING, PERSONNEL SUBCOMMITTEE

FOREIGN AFFAIRS

EDUCATION AND LABOR

HOUSE POLICY

Congress of the United States
House of Representatives

July 11, 2012

COUNTIES:

AIKEN*

ALLENDALE

BARNWELL

BEAUFORT

CALHOUN*

HAMPTON

JASPER

LEXINGTON

ORANGEBURG*

RICHLAND*

(*PARTS OF)

W. ERIC DELL

CHIEF OF STAFF

AND COUNSEL

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

RECEIVED

JUL 16 2012

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

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dear Director Keck,

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

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

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

Very truly yours,



JOE WILSON
Member of Congress

JW/TF



CONGRESSMAN JOE WILSON

Second District of South Carolina

Privacy Release

Consent for Release of Personal Records by Executive Agencies

To Whom It May Concern:

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

Name of Agency: Medicare

X ELLIS R. REYNOLDS
Name (please print)

X 1A-19-1944
Date of Birth

X _____
Address City Zip

X 51 TROON WAY Aiken, SC 29803
Social Security Number E-mail Address

X 247-74-6835 803-649-1657
Telephone Number - Home Telephone Number - Cell

X ~~Ellis~~ Ellis R. Reynolds July 9 2012
Signature Today's Date

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

Concerns with Medicare Billing. Potential
irregularities.

EXPLANATION OF BENEFITS**THIS IS NOT A BILL**

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



BARBARA C REYNOLDS
 51 TROON WAY
 AIKEN SC 29803

688318 000881
 0003 OF 0004

March 16, 2011

STATE HEALTH PLAN**SUMMARY INFORMATION**

Patient's Name ELLIS REYNOLDS		Relationship to Policyholder SPOUSE	ID No. ZCS08393041	Claim No. 1C707492U-00-00
TOTAL CHARGE FOR YOUR CLAIM:	138.00	TOTAL AMOUNT WE PAID:	19.62	WHAT YOU OWE PROVIDER: 00
		Sent to Provider	The provider can bill you for this amount if you have not yet paid.	
To date, you have satisfied 00 of the 200.00 deductible for the benefit period that began 01/01/2011.				
We paid a total of 416.80 for this person this benefit period.				

Medicare paid 78.47.

We have paid 19.62.

You owe your provider .00.

MEDICARE COORDINATED CLAIM

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

* Please refer to the remarks section.

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

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

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BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688318 000861
0003 of 0004

March 16, 2011

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www.SouthCarolinaBlues.com



ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

CUSTOMER SERVICE INFORMATION

Your Medicare Number: XXX-XX-6835A

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

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

Appeals Address: Please see the
General Information Section

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

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

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

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

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



ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

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Dr. Kulik, Ann M. M.D.						
11/23/10	1.0 Office/outpatient visit est (99214)	\$120.00	\$96.56	\$77.25	\$19.31	b

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

686142 250283
0001 of 0002

I-20 @ Alpine Road
Columbia, SC 29219



**BlueCross BlueShield
of South Carolina**

An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

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



BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

688318 000881
0004 of 0004

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011

Patient's Name ELLIS REYNOLDS		Relationship to Policyholder SPOUSE		ID No. ZCS08393041	Claim No. 1C730246U-00-00
TOTAL CHARGE FOR YOUR CLAIM:	361.00	TOTAL AMOUNT WE PAID:	10.21	WHAT YOU OWE PROVIDER:	.00
		Sent to Provider		The provider can bill you for this amount if you have not yet paid.	
To date, you have satisfied .00 of the 200.00 deductible for the benefit period that began 01/01/2011.					
We paid a total of 439.45 for this person this benefit period.					

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

MEDICARE COORDINATED CLAIM

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

* Please refer to the remarks section.

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

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

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SUMMARY INFORMATION

March 16, 2011

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March 10, 2011



ELLIS R REYNOLDS
51 TROON WAY
AIKEN SC 29803-5679

CUSTOMER SERVICE INFORMATION

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686142 250283
0001 OF 0002

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

(706)855-2767

DATE	ACCOUNT NUMBER
Jun 30, 2011	12284-01
AMOUNT PAID _____	

Next Appt:

RESPONSIBLE PARTY
ELLIS R REYNOLDS 51 TROON WAY Aiken, SC 29803

PATIENT
ELLIS R REYNOLDS 51 TROON WAY Aiken, SC 29803

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

DATE	TREATMENT CODE	UNITS	DESCRIPTION	PLACE OF SERV.	PROVIDER	CHARGES	PAYMENTS	INS. BILLED																								
05/31/11			Previous Balance			158.81																										
<table border="1"> <thead> <tr> <th>LAST PAYMENT DATE</th> <th>LAST PAYMENT AMOUNT</th> <th>CURRENT</th> <th>30-60</th> <th>60-90</th> <th>90-120</th> <th>OVER 120</th> <th>TOTAL DUE</th> </tr> </thead> <tbody> <tr> <td>Ins 12/08/10</td> <td>143.72</td> <td>0.00</td> <td>55.71</td> <td>0.00</td> <td>55.29</td> <td>19.41</td> <td></td> </tr> <tr> <td>Pat 11/13/08</td> <td>10.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>28.40</td> <td>28.40</td> </tr> </tbody> </table>									LAST PAYMENT DATE	LAST PAYMENT AMOUNT	CURRENT	30-60	60-90	90-120	OVER 120	TOTAL DUE	Ins 12/08/10	143.72	0.00	55.71	0.00	55.29	19.41		Pat 11/13/08	10.00	0.00	0.00	0.00	0.00	28.40	28.40
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There are Charges that have NOT been posted in our database for May. Please call Kirstie at (706) 855-2767 ext. #18 if you have any questions. PAYMENT DUE UPON RECEIPT.				<table border="1"> <tr> <td>PATIENT NAME</td> <td>ELLIS R REYNOLDS</td> </tr> <tr> <td>ACCOUNT NUMBER</td> <td>12284-01</td> </tr> </table>					PATIENT NAME	ELLIS R REYNOLDS	ACCOUNT NUMBER	12284-01																				
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(706)855-2767

Next Appt:

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51 TROON WAY
Aiken, SC 29803

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<p>There are Charges that have NOT been posted in our database for May. Please call Sandy at (706) 855-2767 ext. #28 if you have any questions.</p> <p>ADVANTAGE FORMS & SYSTEMS INC. 300-953-2790 PRINTED IN U.S.A.</p>				<p>PATIENT NAME</p>		<p>ELLIS R REYNOLDS</p>																																						
<p>PAYMENT DUE UPON RECEIPT</p>				<p>ACCOUNT NUMBER</p>		<p>12284-01</p>																																						

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

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

Notes Section:

- a The approved amount is based on a special payment method.
- b This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. Your private insurer(s) is BCBS OF SOUTH CAROLINA.
- c This surgery was reduced because it was performed with another surgery on the same day.

(continued)

*I question all charged amounts for Post
15 mos.*

*Over. Co charged for deadly drugs!
I Called both ins. cos to report fraud -
both to reps. replied: "they didn't care!"
Please investigate! Health has declined*

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

(706)855-2767

DATE	ACCOUNT NUMBER
Jan 18, 2011	12284-01
AMOUNT PAID _____	

Next Appt:

RESPONSIBLE PARTY
ELLIS R REYNOLDS 51 TROON WAY Aiken, SC 29803

PATIENT
ELLIS R REYNOLDS 51 TROON WAY Aiken, SC 29803

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

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

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

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

PATIENT NAME	ELLIS R REYNOLDS
ACCOUNT NUMBER	12284-01



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

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

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

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

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

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



688318 000881
0001 of 0004

BARBARA C REYNOLDS
51 TROON WAY
AIKEN SC 29803

MCDONALD
1 800 868 909
GREENWOOD

withon
1301 GERMAN
SUITE
350

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

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

STATE HEALTH PLAN

SUMMARY INFORMATION

March 16, 2011
Check No.: 0001914093

Patient's Name ELLIS REYNOLDS		Relationship to Policyholder SPOUSE		ID No. ZCS08393041	Claim No. 1C730304U-00-00
TOTAL CHARGE FOR YOUR CLAIM:	125.00	TOTAL AMOUNT WE PAID:	22.55	WHAT YOU OWE PROVIDER(S): .00	
Payment Enclosed				The provider(s) can bill you for this amount if you have not yet paid.	
To date, you have satisfied .00 of the 200.00 deductible for the benefit period that began 01/01/2010.					
We paid a total of 1,377.41 for this person this benefit period.					

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

MEDICARE COORDINATED CLAIM

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

* Please refer to the remarks section.

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

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com



SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

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

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

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

Claim Number:	0D607650U-00-00	PROVIDER: AUGUSTA PAIN MANAG NON-PARTICIPATING PROVIDER				Date(s) of Service:	Amount Provider May Bill You	
Your Provider Charged	Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid	Amount Paid to Your Provider	Amount Paid to Your Provider
150.00	0.00	18.99	0.00	94.96	75.97	0.00	0.00	18.99
To date, you have satisfied <u>0.00</u> of the <u>200.00</u> deductible for the benefit period that began <u>01/01/2010</u> . This claim contributed <u>0.00</u> toward your out-of-pocket maximum. You have satisfied <u>0.00</u> of the <u>0.00</u> out-of-pocket maximum for this benefit period. We paid a total of <u>602.24</u> for this person this benefit period.								

Claim Number:	0D676279U-00-00	PROVIDER: THE FOOT AND ANKLE NON-PARTICIPATING PROVIDER				Date(s) of Service:	Amount Provider May Bill You	
Your Provider Charged	Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved	Medicare Paid	Amount We Paid	Amount Paid to Your Provider	Amount Paid to Your Provider
62.00	0.00	12.40	12.40	62.00	49.60	12.40	12.40	12.40
81.00	0.00	16.20	16.20	81.00	64.80	16.20	16.20	16.20
24.00	0.00	4.80	4.80	24.00	19.20	4.80	4.80	4.80
28.00	0.00	5.60	5.60	28.00	22.40	5.60	5.60	5.60
TOTAL:	195.00	39.00	39.00	195.00	156.00	39.00	39.00	39.00
To date, you have satisfied <u>0.00</u> of the <u>200.00</u> deductible for the benefit period that began <u>01/01/2010</u> . This claim contributed <u>0.00</u> toward your out-of-pocket maximum. You have satisfied <u>0.00</u> of the <u>0.00</u> out-of-pocket maximum for this benefit period. We paid a total of <u>641.24</u> for this person this benefit period.								

*** REMARKS:**

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

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

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

Brenda James

From: Teeshla Curtis
Sent: Wednesday, August 01, 2012 9:34 AM
To: Brenda James
Subject: FW: Email to Close Log 0021
Attachments: Cong. Wilson - Ellis Reynolds.pdf

Log 21 was closed July 19th through an email correspondence Congressman Wilson's office. The letter we received from the Congressman was regarding Medicare billing. Jenny forwarded the original correspondence to the Office on Aging (details in the emails below).

Teeshla

From: Jennifer Lynch
Sent: Wednesday, August 01, 2012 9:20 AM
To: Teeshla Curtis
Subject: FW: Email to Close Log 0021

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:37 AM
To: Brenda James
Subject: Email to Close Log 0021

Email sent to Mr. Felder, Congressman Wilson's staffer.

From: Jennifer Lynch
Sent: Thursday, July 19, 2012 10:37 AM
To: ted.felder@mail.house.gov
Cc: Gloria McDonald
Subject: Congressman Wilson Constituent Letter - Ellis Reynolds

Mr. Felder,

Attached is a referral our office received that is regarding a Medicare billing issue. Since our agency does not handle Medicare billing, I am copying Gloria McDonald with the Office on Aging to determine if she can assist. Gloria: Please research and respond back to Mr. Felder.

Thanks,

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