

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>7-1-08</i>
--------------------	-----------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>000007</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR <i>Cleaved 7/11/08, attus attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>7-11-08</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.			

*John B. & Colleen S. Zeigler, 101 Benson Drive, Swailews Rest, SC 29690  
(864) 834 - 3661*

June 24<sup>th</sup>, 2008

To: Director of Medical Services

Medicaid

Department of Health and Human Services

P.O. Box 8206

Columbia, SC 29202

**RECEIVED**

JUL 01 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Dear Director:

I am writing on behalf of my disabled daughter (Shannon L. Zeigler - 248-81-6804) who upon the assessment of Dr. Gault in Greenville, SC, was recommended to use a home CPAP machine. This is a common occurrence for Prader-Willi Syndrome patients, especially as they mature into their adult years (Shannon is eighteen).

The company that provided the CPAP machine (Advantage Home Medical Co., 1200 Woodruff Road, Ste. C-37, Greenville, SC 29607), agreed as per their contract to bill my employer's health plan (through Kanawha at the time) and to secondarily bill Medicaid. Kanawha treated their company as outside of its approved network (though Advantage Home Medical had assured my wife and daughter that they were within the network on initiation of their contract), and consequently paid little toward the claim.

At that point Advantage should have billed Medicaid, but instead they charged us with the unpaid expenses (ten months had elapsed since the contract was initiated, and they still hadn't billed Medicaid, to my knowledge). When we informed Advantage that we couldn't pay the "rental fee" that they had apparently transitioned the agreement to (according to their methods - not upon our agreement or consent) they promptly came to our house and collected their equipment. Advantage has since elected to seek their payment via the collections route, still without having billed Medicaid.

I am attaching the documentation that has accumulated through-out this process for your perusal and judgment, and requesting that the appropriate Medicaid payment be made to Advantage, or a claims consideration letter of explanation be forwarded to them in order that this issue might be resolved.

Ms. Irma Bishop is the contact person at Advantage - (864) 627-9669.

Sincerely,

  
John Zeigler

*John B. & Colleen S. Zeigler, 101 Benisan Drive, Travelers Rest, SC 29690  
(864) 834-3661*

06-01-08

Irma Bishop  
Advantage Home Medical Co.

Dear Ms. Bishop:

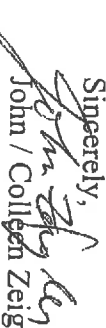
Colleen and I thank you for your diligence in trying to work through the appropriate billing processes for the CPAP machine that Advantage Home Medical provided for Shannon for a limited time.

We have reviewed the contract agreement that was established with Advantage and have talked with Dr. Gault's office about the usual and customary contracts that your company operates with through his office. We have concluded that we never agreed to an equipment rental agreement through Advantage Home Medical (see attached copies of contract paperwork with Advantage). Indeed the idea of transitioning your billings to a rental agreement was not enacted until seven months into services when you determined that our insurance carrier would treat your company as an unapproved provider.

We have continued to pursue payment through Kanawha for your services, and have attached for your consideration an Explanation of Benefits form that shows Kanawha as having treated your services as provided by an "out-of-network provider," and have consequently considered charges at a 50% coverage rate, and applied the submitted charges against Shannon's annual deductible. In accord with your contract, the next step in this process should be for your company to submit these considered charges to Medicaid for reimbursement, as Medicaid is the secondary payor in Shannon's case, and submit all other relevant charges to Kanawha for their "first payor" consideration, and follow up their response by submitting to Medicaid.

At no point in this process can we find where Shannon, or her legal assigns, agreed to a rental agreement with Advantage Home Medical. The provision of services was enacted through Dr. Gault's office with payment responsibilities to be submitted to our representative insurance carrier, and secondarily to Medicaid.

We respectfully returned your company's equipment as soon as we were informed that you were having difficulty with the insurance filing. We regret any difficulty that you have encountered with filing insurances, but we cannot accept responsibility for contracts that were enacted with Dr. Gault's office, completely apart from our involvement.

Sincerely,  
  
John / Colleen Zeigler

# ADVANTAGE

HOME MEDICAL CO.

5/01/08

John B. Ziegler  
101 Benson Drive  
Travelers Rest, SC 29690

Re: Shannon

Dear Mr. Ziegler:

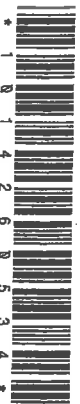
As we discussed previously, the debt is still outstanding for the CPAP rental for Shannon during the six months she had the machine. Notwithstanding that your insurance has denied payment and you have switched providers, this debt is still current.

Please remit payment as soon as possible to avoid collection activity.

Sincerely,

Irma Bishop  
Billing

**Address Service Requested**



JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS RST, SC 29690-8781

**If You Have Any Questions Call Our  
Customer Service Department at  
(800) 822-1274  
Visit us at [www.khsonline.com](http://www.khsonline.com)**

**Claim No.:** 073313828G  
**Approver:** 033  
**Ins/Mem:** JOHN B ZEIGLER  
**ID#:** 0000015739  
**Claimant:** SHANNON L ZEIGLER  
**Patient#:** AHM240055  
**Date:** 12/04/2007  
**Group:** HEALTHEFIRST  
**Group#:** GHS001  
**Location#:** 0010008  
**Check#:** 0

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information contact us online at [khsonline.com](http://khsonline.com)

**EXPLANATION OF BENEFITS**

Line No.	Provider	Date(s) Of Service	Procedure	Proc Code	Total Charges	Excluded Charges	Co-Pay	Deductible	Covered Expense	Paid At	Balance Paid By Plan
01	ADVANTAGE HOME MEDICA	09/05/07 - 09/05/07	MED EQUIP	E0601	139.64	0.00	0.00	139.64	0.00	50%	0.00
02	ADVANTAGE HOME MEDICA	10/05/07 - 10/05/07	MED EQUIP	E0601	139.64	0.00	0.00	139.64	0.00	50%	0.00
<b>TOTALS</b>					279.28	0.00	0.00	279.28	0.00		0.00
<b>To Be Paid By Plan</b>											0.00
<b>Patient Responsibility to Provider</b>											279.28

**Accumulators**

2007 Medical deductible remaining - Individual: 720.72 Family: 3,220.72

**Payment To**

N/A

**Amount**

**Claim Remarks**

Line No.

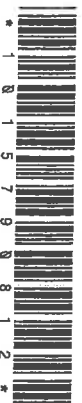
**Explanation**

01, 02 Benefits reduced. Services were not rendered by a network provider. Refer to the provisions in your plan document regarding network providers.

01, 02 Payment has been applied to your deductible. Refer to the schedule in your plan document for the copayment, deductible, and limits applicable to this service.

Upon request at no charge KHS will provide you the internal rules, guidelines, protocols, criteria, or standards for determining medical necessity, experimental treatment or similar exclusions or limits, which were relied on in making this determination. You or an authorized representative may appeal this determination by following a 2-level appeal procedure. To file a Level 1 Appeal, send KHS a written request within 180 days of receipt of this notice to P.O. Box 1000, Lancaster, SC 29721. You may submit written comments, documents, records and other information relating to this claim. On request at no charge KHS will provide you copies of information relevant to this claim, which will be reviewed even if not considered in the original determination. The Level 1 Appeal will not be reviewed by the person who made the initial determination nor a subordinate thereof, and no deference will be given to the initial determination. If the initial determination was based in any way on a medical judgment, the plan administrator will consult with a health care professional(s) neither involved in the initial determination nor a subordinate thereof. On request KHS will provide the identity(ies) of the medical or vocational experts utilized during the appeal. You will be notified of the Level 1 Appeal decision within 15 days (pre-service claim) or 30 days (post-service claim) of the date the Plan receives the appeal. If the appeal is denied, you may file a Level 2 Appeal within 60 days of the date you receive the Level 1 Appeal decision. Level 1 Appeal procedures will apply to Level 2 Appeals. If the Level 2 Appeal is denied, you may elect voluntary arbitration. For further information, please consult your summary plan description.

**Address Service Requested**



JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS RST, SC 29690-8781

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**Claim No.:** 073323697G  
**Approver:** SGM  
**Ins/Mem:** JOHN B ZEIGLER  
**ID#:** 0000015739  
**Claimant:** SHANNON L ZEIGLER  
**Patient#:** AHM240055  
**Date:** 12/07/2007  
**Group:** HEALTHFIRST  
**Group#:** GHS001  
**Location#:** 0010008  
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<b>TOTALS</b>					139.64	0.00	0.00	139.64	0.00		0.00
										To Be Paid By Plan	
										Patient Responsibility to Provider	
										139.64	

**Accumulators**  
2007 Medical deductible remaining - Individual: 581.08 Family: 3,081.08

**Payment To**  
N/A

**Amount**

**Claim Remarks**

**Line No.**

**Explanation**

01 Benefits reduced. Services were not rendered by a network provider. Refer to the provisions in your plan document regarding network providers.

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**Address Service Requested**



JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29160-8781

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<b>TOTALS</b>					<b>279.28</b>	<b>0.00</b>	<b>0.00</b>	<b>279.28</b>	<b>0.00</b>		<b>0.00</b>
To Be Paid By Plan											0.00
Patient Responsibility to Provider											279.28

**Accumulators**

2007 Medical deductible remaining - Individual: 720.72 Family: 3,220.72

**Payment To**  
N/A

**Amount**

**Claim Remarks**

Line No.

**Explanation**

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JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29690-8781

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										To Be Paid By Plan	
										Patient Responsibility to Provider	
										139.64	

**Accumulators**

2007 Medical deductible remaining - Individual: 581.08 Family: 3,081.08

**Payment To**  
N/A

**Amount**

**Claim Remarks**

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\* 1 8 1 4 2 6 8 5 3 4 \*



JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29690-8781

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**Accumulators**

2007 Medical deductible remaining - Individual: 720.72 Family: 3,220.72

**Payment To** **Amount**  
N/A

**Claim Remarks**

Line No.

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JOHN B. ZEIGLER  
101 BENSON DR  
TRAVELERS RST, SC 29690-8781

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<b>Patient Responsibility to Provider</b>											139.64

**Accumulators**

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N/A

**Amount**

**Claim Remarks**

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# ADVANTAGE HOME MEDICAL CO.

## AUTHORIZATION FOR PAYMENT RELEASE OF INFORMATION AND INFORMED CONSENT STATEMENT SUPPLIER STANDARDS (REVERSE SIDE)

The following is to be completed upon admission or initiation of service:

Beneficiary's Name: Sharon Leigh Zeigler  
(First) (Middle) (Last)  
Medicare/Insurance No.: 000015739  
Address: Medicaid 88885551001

### SUPPLIER STANDARDS

Advantage Home Medical Co. adheres to the DMEPOS Supplier Standards on the reverse side of this form.

### AUTHORIZATION FOR PAYMENT

I acknowledge that my choice of Advantage Home Medical Co. as a supplier, is made freely, recognizing that there are other companies that offer similar services. I request that payment of authorized insurance benefits, including Medicaid, be made to Advantage Home Medical Co. for any unpaid bills for: Infusion therapy, enteral nutrients, ostomy, tracheostomy and urological supplies, medication pump(s), surgical dressings and related equipment, durable medical equipment, oxygen, and supplies. Among services provided may be the rental of an enteral infusion pump, durable medical equipment (DME), and prescription drugs related to DME. I understand that I may choose to purchase the equipment at any time by notifying Advantage Home Medical Co. of my decision. I also understand that I may purchase capped rental durable medical equipment in the tenth month of rental, if I so choose.

### RELEASE OF INFORMATION

I authorize the holder of any medical information about me to release to the insurance company, Medicare Carrier or Advantage Home Medical Co. any information needed to determine benefits payable. I authorize any insurance company, Medicare carrier or the Social Security Administration to disclose information to Advantage Home Medical Co. necessary to process a claim for benefits on my behalf.

Beneficiary's Signature: (Signature)  
Witness: Sharon Leigh Zeigler Date: 20-05-07

NOTE: If the beneficiary is unable to sign, the patient's representative or the facility's representative should sign the beneficiary's name on the beneficiary's signature line, followed by the word "by", followed by the representative's own name. If someone other than the beneficiary signs the form, please provide additional information below.

The following is to be completed if signed by someone other than the beneficiary:

Name: (Please print representative's name) Sharon Leigh Zeigler  
Address: Medicaid 88885551001  
Reason Beneficiary could not sign: cannot sign  
Account number(s) \_\_\_\_\_

**ADVANTAGE**

Home Medical Co.

**DELIVERY TICKET****PICK-UP TICKET****Service/Repair Ticket****P/U Reason:**

Recovered

Expired:

Transferred to:

Hospital/N. Home on:

Patient Name Shannon ZeiglerDate 02-13-07

Time:

Address: 101 Benson Dr.Referred by: Pediatric SleepTravelers Rest, SC

Date/Time of order:

Pt. Phone: 834-3461

Emergency Contact:

Primary Payor: KavanaughSecondary Payor: Medicaid

Date of Discharge:

Equipment	Model/Item#	Serial Number
Straight Cane	# Std Offset Foam-grip Other	N/A
Folding walker	# Reg Jr. Hemi-Walk H.Duty Bariatric	N/A
Wheeled walker	# Reg Jr. Hemi-Walk H.Duty Bariatric	N/A
Wheelchair	# Std Hemi Lr.Wt. H.Duty Bariatric	
Legrests:	# Swing-Away Elevating Articulating	N/A
Bedside Commode	# Reg Drop-Arm H.Duty Bariatric	N/A
Hospital Bed	# Lo-Bed Semi-Elec F/Electr	
Alternating Pressure Pad	#	
Alternating Pressure Mattress	#	
Trapeze Bar	# Bed Attached Free-Standing	
Hoyer lift	# Sling size: S M L XLg Full Body	
Oxygen concentrator	# Respironics Invacare Sunrise	
Portable oxygen tanks	Size: M6 D E H Reg: Std C.Device	
Nebulizer	#	
Suction Machine	#	
CPAP/BiPAP	#	
Humidifier	# Heated Non-Heated	
Additional sleep supplies: <u>chin strap, disp. filters x 2</u>		
OTHER ITEMS:		

If equipment is related to mobility, was a home assessment done? Yes No Technician's Initials:

**PATIENT FINANCIAL RESPONSIBILITY:** The customary charge(s) for the items delivered is/are \$ purchased/rental per month. Your estimated portion of these costs is \$, one time charge/monthly rental. If you have supplemental coverage, notify us of the carrier and subscriber number.**HOURS OF OPERATION & HOW TO CONTACT US:**

We are open for business Monday-Friday from 8:00am-5:00pm. and on-call for emergencies. You may call us at either: 1-888-390-5533 or 1-864-627-9669 concerning equipment or billing issues.

Patient/Responsible Party Signature

For Advantage Home Medical Company

Subtotal

Tax

Grand Total

\*\* 3 day refund/replacement on selected items \*\*

**ADVANTAGE**

Home Medical Co.

**DELIVERY TICKET**☒ **PICK-UP TICKET**☐ **Service/Repair Ticket****P/U Reason:**☐ Recovered☐ Expired:☐ Transferred to:

Hospital/N. Home on:

Patient Name

Sharon Siegel

Date

2-22-08

Time:

4:25

Address:

101 Haven Ct

Referred by:

Date/Time of order:

Pt. Phone:

394-3661

Emergency Contact:

Primary Payor:

Secondary Payor:

Date of Discharge:

Equipment	Model/Item#	Serial Number
Straight Cane	# <u>      </u> Std Offset Foam-grip Other	N/A
Folding walker	# <u>      </u> Reg Jr. Hemi-Walk H.Duty Bariatric	N/A
Wheeled walker	# <u>      </u> Reg Jr. Hemi-Walk H.Duty Bariatric	N/A
Wheelchair	# <u>      </u> Std Hemi Lt.Wt. H.Duty Bariatric	
Legrests:	# <u>      </u> Swing-Away Elevating Articulating	N/A
Bedside Commode	# <u>      </u> Reg Drop-Arm H.Duty Bariatric	N/A
Hospital Bed	# <u>      </u> Lo-Bed Semi-Elec F.Electr	
Alternating Pressure Pad	# <u>      </u>	
Alternating Pressure Mattress	# <u>      </u>	
Trapeze Bar	# <u>      </u> Bed Attached Free-Standing	
Hoyer lift	# <u>      </u> Sling size: S M L XLg Full Body	
Oxygen concentrator	# <u>      </u> Respironics Invacare Sunrise	
Portable oxygen tanks	Size: M6 D <u>      </u> E <u>      </u> H <u>      </u> Reg: Std C.Device	
Nebulizer	# <u>      </u>	
Suction Machine	# <u>      </u>	
CPAP/BiPAP	# <u>      </u>	
Humidifier	# <u>      </u> Heated Non-Heated	

Additional sleep supplies: \_\_\_\_\_

OTHER ITEMS: \_\_\_\_\_

2 in. x 2 in. x 1/2 in. - 104 (100000)

If equipment is related to mobility, was a home assessment done? ☐ Yes ☐ No Technician's Initials: \_\_\_\_\_

**PATIENT FINANCIAL RESPONSIBILITY:** The customary charge(s) for the items delivered is/are \$ \_\_\_\_\_ purchased/rental per month. Your estimated portion of these costs is \$ \_\_\_\_\_, one time charge/monthly rental. If you have supplemental coverage, notify us of the carrier and subscriber number.

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1-888-390-5533 or 1-864-627-9669 concerning equipment or billing issues.

Patient/Responsible Party Signature

For Advantage Home Medical Company

Subtotal

Tax

Grand Total

**\*\* 3 day refund/replacement on selected items \*\***

**ADVANTAGE**

Home Medical Co.

☒ DELIVERY TICKET

P/U Reason:

☐ PICK-UP TICKET☐ Recovered☐ Service/Repair Ticket☐ Expired:☐ Transferred to:

Hospital/N. Home on: \_\_\_\_\_

Patient Name Shannon L. ZeiglerDate 02-05-07Time: 11:00Address: 101 Benson DriveReferred by: Pediatric SleepWarders Rest, SC 29690Date/Time of order: 03-31-07Pt. Phone: 844-334-3401Emergency Contact: Coleen 918-3334Primary Payor: KaravashSecondary Payor: Medicaid Date of Discharge: \_\_\_\_\_

Equipment	Model/Item#	Serial Number
Straight Cane	# _____ Std Offset Foam-grip Other _____	N/A
Folding walker	# _____ Reg Jr. Hemi-Walk H.Duty Bariatric _____	N/A
Wheeled walker	# _____ Reg Jr. Hemi-Walk H.Duty Bariatric _____	N/A
Wheelchair	# _____ Std Hemi Lt. Wt. H.Duty Bariatric _____	N/A
Legrests:	# _____ Swing-Away Elevating Articulating _____	N/A
Bedside Commode	# _____ Reg Drop-Arm H.Duty Bariatric _____	N/A
Hospital Bed	# _____ Lo-Bed Semi-Elec F.Electr _____	
Alternating Pressure Pad	# _____	
Alternating Pressure Mattress	# _____	
Trapeze Bar	# _____ Bed Attached Free-Standing _____	
Hoyer lift	# _____ Sling size: S M L XLg Full Body _____	
Oxygen concentrator	# _____ Respironics Invacare Sunrise _____	
Portable oxygen tanks	Size: M6 D _____ E _____ H _____ Reg: Std C.Device _____	
Nebulizer	# _____	
Suction Machine	# _____	
CPAP/BiPAP	# <u>33021</u> <u>SB Elite</u>	<u>20070292045</u>
Humidifier	# <u>33900</u> (Heated) Non-Heated _____	<u>20070138865</u>
Additional sleep supplies:		
<u>4 tubing, disp. filter x1, Swift nasal pillows</u>		
OTHER ITEMS: <u>00512</u>		

If equipment is related to mobility, was a home assessment done? Yes ☐ No ☐ Technician's Initials: \_\_\_\_\_

PATIENT FINANCIAL RESPONSIBILITY: The customary charge(s) for the items delivered is/are \$ \_\_\_\_\_ purchased/rental per month. Your estimated portion of these costs is \$ \_\_\_\_\_, one time charge/monthly rental. If you have supplemental coverage, notify us of the carrier and subscriber number.

**HOURS OF OPERATION & HOW TO CONTACT US:**

We are open for business Monday-Friday from 8:00am-5:00pm. and on-call for emergencies. You may call us at either: 1-888-390-5533 or 1-864-627-9669 concerning equipment or billing issues.

Patient/Responsible Party Signature \_\_\_\_\_

For Advantage Home Medical Company

Subtotal \_\_\_\_\_

Tax \_\_\_\_\_

Grand Total \_\_\_\_\_

\*\* 3 day refund/replacement on selected items \*\*

ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

RETURN SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
04/30/2008	867.61	AHMM240055

FOR BILLING INQUIRIES, PLEASE CALL 864-627-9669

SHOW AMOUNT PAID HERE	\$

**FOR BILLING INQUIRIES, PLEASE CALL 864-627-9669**

**ADDRESSEE:**

**MAKE CHECKS PAYABLE TO:**

SHANNON ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29690-8781

ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Service Date	Description	Charge	Allowed	Insurance Paid	You Paid	Balance	Status
06/05/2007	MASK FOR CPAP	147.05	0.00	0.00	0.00	147.05	Due from patient
06/05/2007	HEADGEAR FOR CPAP	45.54	0.00	0.00	0.00	45.54	Due from patient
06/05/2007	TUBING FOR CPAP	50.32	0.00	0.00	0.00	50.32	Due from patient
06/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	0.00	0.00	0.00	101.00	Due from patient
06/13/2007	CHINSTRAP FOR CPAP	18.70	0.00	0.00	0.00	18.70	Due from patient
07/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	0.00	0.00	0.00	101.00	Due from patient
08/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	0.00	0.00	0.00	101.00	Due from patient
09/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	101.00	PAST DUE - (3)
10/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	101.00	PAST DUE - (3)
11/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	0.00	0.00	0.00	101.00	Due from patient

Date	Account
04/30/2008	AHIN240055

## Pay This Amount

867.61

Attending Physician	Dr. Gault - (864) 454-5668
Insurance 1	KANAWHA HEALTHCARE
Insurance 2	PT PAY

**Billing Inquiries Call: 864-627-9669**

# Advantage Home Medical Company

1200 Woodruff Road Ste C-37  
Greenville, SC 29607

# Invoice

Date	Invoice #
4/30/2008	16874

<b>Bill To</b>  Shannon Ziegler c/o John B. Ziegler 101 Benson Drive Travelers Rest, SC 29690
--

P.O. No.	Terms

No. of Days	Description	Rate	Amount
6	CPAP-Customer	101.00	606.00T
1	CPAP Mask	147.05	147.05T
1	CPAP Filters	18.70	18.70T
1	Chin Strap	20.00	20.00T
		0.00	0.00
	CPAP and heated humidifier rental x 6 months.		
	Sales Tax	5.00%	39.59
Thank you for your business!!		<b>Total</b>	\$831.34



ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

RETURN SERVICE REQUESTED

FOR BILLING INQUIRIES, PLEASE CALL 864-627-9669

ADDRESSEE:

MAKE CHECKS PAYABLE TO:

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
02/29/2008	286.38	AHM240055
SHOW AMOUNT PAID HERE		\$

SHANNON ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29690-8781  
|||||||

ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

**STATEMENT**

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Service Date	Description	Charge	Allowed	Insurance Paid	You Paid	Balance	Status
06/05/2007	REPLACEMENT NASAL PILLOWS	35.51	35.51	-28.41	0.00	7.10	PAST DUE - (4)
09/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	139.64	Due from patient
10/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	139.64	Due from patient

Date	Account
02/29/2008	AHM240055

Pay This Amount
286.38

Attending Physician	Dr. Gault - (864) 454-5668
Insurance 1	KANAWHA HEALTHCARE
Insurance 2	PT PAY

Billing Inquiries Call: 864-627-9669

ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

RETURN SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
01/31/2008	286.38	AHM240055
SHOW AMOUNT \$		
PAID HERE		

**FOR BILLING INQUIRIES, PLEASE CALL 864-627-9669**

**ADDRESSEE:**

**MAKE CHECKS PAYABLE TO:**

SHANNON ZEIGLER  
101 BENSON DR  
TRAVELERS REST, SC 29690-8781

ADVANTAGE HOME MEDICAL  
1200 WOODRUFF RD STE C37  
GREENVILLE SC 296075731

## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Service Date	Description	Charge	Allowed	Insurance Paid	You Paid	Balance	Status
6/05/2007	REPLACEMENT NASAL PILLOWS	35.51	35.51	-28.41	0.00	7.10	PAST DUE - (3)
9/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	139.64	Due from patient
0/05/2007	CONTINUOUS AIRWAY PRESS CP	139.64	139.64	0.00	0.00	139.64	Due from patient

Date	Account
01/31/2008	AHNM240055

## Pay This Amount

286.38

Attending Physician	Dr. Gault - (864) 454-5668
Insurance 1	KANAWHA HEALTHCARE
Insurance 2	PT PAY

**Billing Inquiries Call: 866-627-9669**





State of South Carolina  
Department of Health and Human Services

Mark Sanford  
Governor

Emma Forkner  
Director

July 11, 2008

Mr. John Zeigler  
101 Benson Drive  
Travelers Rest, South Carolina 29690

Dear Mr. Zeigler:

Thank you for your recent inquiry regarding the provision and reimbursement of a home Continuous Positive Air Pressure (CPAP) unit for your daughter, Shannon Zeigler, by Advantage Home Medical Company of Greenville, South Carolina. Our records indicate that Shannon is an eligible beneficiary of the SC Medicaid program. If criteria are met, home CPAP therapy is a covered service under the SC Medicaid Durable Medical Equipment (DME) program. The program reimburses for unit rentals on a monthly basis. We have verified that Advantage Home Medical is an enrolled SC Medicaid DME provider.

You are correct in your statement that SC Medicaid would be the secondary payer to other health insurance coverage that Shannon has. If Advantage Home Medical accepted Shannon as a Medicaid patient, and from the information you submitted it appears that this is the case, then the proper billing procedure would be for Advantage Home Medical to bill the primary insurance first. Advantage would then bill SC Medicaid secondarily for any remaining payment due. SC Medicaid would reimburse, as the secondary payer, an amount up to the allowed payment amount as established by the DME program's fee schedule. Advantage Home Medical should accept these coordinated payments as payment in full.

Program staff for the DME program has spoken with the billing department of Advantage Home Medical. Advantage now has a better understanding of how SC Medicaid coordinates benefits and indicated they would bill SC Medicaid for the services rendered to Shannon.

If you have other questions regarding this matter, please contact Mr. Mike Blakely, Team Leader for Pharmacy and DME Services, at (803) 898-2872. We are pleased that we were able to assist you in resolving this issue.

Sincerely,

*Charles Michael Blakely*

Charles Michael Blakely, R.Ph  
Pharmacy and DME Services

CMB/gsd

Log #7