

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Jacobs</i>	DATE <i>8-31-07</i>
---------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000124	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Cleared 8/31/07 per Jan P. See attached Note.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE 9-18-07
	<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.			



HUGH K. LEATHERMAN, SR.

SOUTH CAROLINA STATE SENATE
DISTRICT 31, FLORENCE
AND DARLINGTON COUNTIES

COMMITTEES
Chairman, Finance
Chairman, Operations and Management

Ethics
Interstate Cooperation
Labor, Commerce and Industry
Rules
State House
Transportation

111 GRESSETTE SENATE OFFICE BUILDING
COLUMBIA, SOUTH CAROLINA 29202

(803) 212-6640

FLORENCE ADDRESS
1817 Pineland Avenue
Florence, South Carolina 29501

(843) 667-1152

August 27, 2007

Emma Forkner, Director
Department of Health & Human Services
1801 Main Street
Columbia, South Carolina 29201

Dear Ms. Forkner:

I am enclosing herewith a copy of a letter, with attachments, that I recently received from Shareefa Bautista, the daughter and caregiver of Rasaul Dillah. As you can see, it appears that Ms. Bautista is having difficulty in getting her father's records to reflect that he had no insurance during 2006 and that his Medicare Part B coverage became effective April 1, of this year.

I would very much appreciate it if you would ask your staff to look into this matter and see that Mr. Dillah's records are corrected and that provider invoices are paid if appropriate.

Thank you for your assistance in this matter.

Very truly yours,

A handwritten signature in dark ink, appearing to read "H. K. Leatherman", written over a horizontal line.

Hugh K. Leatherman, Sr.
HKL:dsm

Enclosure

cc Ms. Shareefa Bautista
13-DI/1

RECEIVED

AUG 29 2007

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Spoke w/ Dean in
Sen Leathers and pri-
OK to close -

No written response
necessary.

8/21 JS

Would this be an
elig. issue or more
modern Sues?
Thank you both.

JS
8/29

The Honorable Hugh K. Leatherman
SC Senate
PO Box 142
Columbia SC 29202

Shareefa Bautista
2109 Abernathy Dr
Florence SC 29505
Tel: 843-664-0765(home)
Tel: 843-669-5162 ext 347
August 24, 2007

Dear Mr. Leatherman:

I am the caregiver for my dad Rasaul Dillah who resides with me at the above address. I am not sure if you could help me or if you could direct me to the right agency that will. My dad is having problems with Medicare and Medicaid office. He did not work long enough in the United States to be eligible for Medicare, he only worked 5 years before he had heart surgery in 1991. He has been living with since 2004, before he resided with my sister in New York. He was on Medicaid last year only. This year he became eligible for Medicare Part B only effective 4-1-2007 since he is now a dialysis patient. The state pays for his premium for Part B only. I have been to Medicaid office several times, called and spoken to his case worker Barbara Ford (843-669-3354 ext 254) to try to get them to update his records that for 2006 he did not have Medicare Part B. She has really tried to get them to update but the Columbia office is not doing what they are suppose to do. All his claims that got paid by Medicaid office last year, Medicaid is recouping their money telling providers that he has other insurance, and he did not for last year Jan to Dec 2006. I do not know what else to do to help my dad. He is now getting bills from providers and he has limited income, he is not eligible for Social Security benefits or SSL.

I am sending proof where I contacted offices and faxed them information needed to get records updated as of today, and nothing has been done. Medicaid office still show he has other insurance for last year and I am sending copy of his medicare card showing his effective date. I spoke to Vivian Buford responsible for transport services in Florence area. The EMS said they could not do anything to get bill paid, I also spoke to provider today. Sending you copy of letter they sent my dad that he was responsible for his bill where Medicaid should be paying for this.

Please advise me further what I could do to get this resolved.

Shareefa Bautista
Shareefa Bautista

Aug. 24, 2007 1:01PM PPS

No. 6889 P. 4.

SOUTH CAROLINA
DEPARTMENT OF MOTOR VEHICLES
DRIVER'S LICENSE

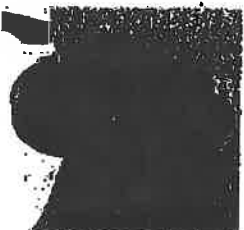
BAUNISTA SHANEEVA DELAH
2108 ABERNATHY DR
FLORENCE SC 29506

DL#: 007404398
Expires: 12-02-2016

Class: D Hgt: 5-02 Wgt: 157
Sex: F DOB: 12-02-1986
Issued: 01-27-2005 21021-211

Shane Delah

Restrictions: A





PHYSICIAN PRACTICE SOLUTIONS, LLC

PO Box 100523
217 DOZIER BLVD, STE 100
FLORENCE, SC 29501

PHONE: (843) 669-5162 or
(843) 669-9255
FAX: (843) 667-4573

Date: 7-11-07

No. of sheets to follow: 10

To: Babara Ford

From: SHARKEEA BAUTISTA

Company: DHHS in PC

Company: FLORENCE RADIOLOGY

Fax #: 629-8192

Fax #: (843) 667-4573

Phone #:

669-3354

Phone #:

(843) 669-5162 EXT 347
(800) 741-6920 ext 347

EMAIL: sbautista@physicianpracticesolutions.com

☒ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

Comments

Good morning hope you are well.
My dad got this in the mail
yesterday after I saw you. I don't
know what else to do. Medicare was
killed, they got the denial and Medicaid
still does not want to pay. See rejections
from Medicare and Medicaid
Please help. Have a blessed day.

Shameek

Coding Disclaimer: Physician Practice Solutions, LLC has made every effort to ensure accuracy of the information provided. Absolute accuracy cannot be guaranteed, however. Given the evolving nature of the rules and regulations surrounding the health care industry, it is recommended that carriers be questioned regarding any new information presented, or any significant changes to current reporting practices, prior to implementation. This information is made available with the understanding that Physician Practice Solutions, LLC is not engaged in rendering legal advice.

FLORENCE COUNTY EMS

180 N. IRBY STREET, MSC-GG
FLORENCE, SC 29501

*Medicaid denied appeal.
Medicare denied payment.
Bill is non-issue
responsibility.*

Patient Name: RASAU DILLAH
Insurance: MEDICAID CLAIMS

43022
286599
03/16/2007

RASAU DILLAH
2109 ABERNATHEY DR
FLORENCE, SC 29505

2109 ABERNATHEY DR
HOSPITAL-CAROLINA HOSPITAL

786.52
786.05

*TKS,
Kathy*

DESCRIPTION OF CHARGES	IT PRICE	AMOUNT
ALS BASE-EMERGENCY		
MILEAGE	1.0	300.00
OXYGEN SUPPLIES	3.0	15.00
EKG SUPPLIES	1.0	50.00
	1.0	50.00
		50.00

Total Charges 415.00

DESCRIPTION OF PAYMENT
REJECTED-MEDICAID
REJECTED-MEDICAID
REJECTED-MEDICAID
REJECTED-MEDICAID
Total All Other Payments

RECEIPT	PAYMENT DATE	AMOUNT
4988521	07/02/2007	0.00
4977272	08/18/2007	0.00
4968501	08/04/2007	0.00
4964446	06/29/2007	0.00

Total Credits 0.00

PLEASE PAY THIS AMOUNT => \$415.00

DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT^

Patient Name: DILLAH, RASAU
Patient Number: 43022

Call Number: 295599
Current Date: 07/06/2007

Amount Due: \$415.00
Amount
Enclosed \$

WE HAVE RECEIVED PAYMENT FROM YOUR INSURANCE COMPANY. THE BALANCE SHOWN ON THIS STATEMENT
REFLECTS THE CO-PAYMENT AMOUNT WHICH IS YOUR RESPONSIBILITY.



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

July 3, 2007

Susan B. Bowling
Acting Director

Florence County EMS
180 North Irby Street, MSC-GG
Florence, South Carolina 29501-3003

RE: Appeal request in the matter of Florence County EMS v. SCDHHS
Recipient: Rasaul Dillah, ID# 7780363932
Appeals' File #07-U-083

Dear Ms. Stewart:

Enclosed please find your submission in the above referenced appeal matter.

Also enclosed is a copy of the South Carolina Medicaid appeals' process found in the South Carolina Medicaid Provider Manual. As you can see, there is no provision for a review, or reconsideration, of rejected claims or partial payments. The South Carolina Medicaid appeal process is a formal evidentiary hearing held here in Columbia, South Carolina. As the policy states, providers should make every effort to work with their program representative to resolve issues in dispute before requesting an appeal, and then only if they desire an evidentiary hearing.

If you desire a hearing, please follow the Manual instructions attached.

If you have any questions, you may call me at 1-800-763-9087.

Sincerely,

Vastine G. Crouch
Vastine G. Crouch
Director
Division of Appeals and Hearings

Enclosure

Division of Appeals
P. O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2600 Fax (803) 255-8206

XXX Provider Manual

01/01/06

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS**

APPEALS

DHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in S.C. Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

An administrative appeal is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should work with their program representative in an effort to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of DHHS, a provider wishing to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Subsequent hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

Current Date: 6/01/07
Medicaid Recipient Name: **Rasaul Dillah**
Medicaid Recipient Number: 7780363932

Provider Name: **Renewed Liberty EMS**
Provider Number: **AB0030**
Contact Person: **R. Stewart**
Telephone Number: **843 665 3011**
Signature of Person Requesting Appeal: **Kathy Stewart**
FAX Number: **843 676 8795**

Data on Claims to be Appealed

<u>Providers</u>	<u>Claim</u>	<u>Service</u>	<u>Proc</u>	<u>Amt</u>	<u>Recipient</u>	<u>Recipient</u>
<u>Ref #</u>	<u>Ref #</u>	<u>Dates</u>	<u>Codes</u>	<u>Billed</u>	<u>ID #</u>	<u>Name</u>
295599	29	03/16/07	A0427	400.00	7780363932	P. Dillah
	Unit	03/16/07	A0425	15.00	"	"

Explain of why you like an Appeal:

Medicaid denied (953) Possible Medicare buy-in file to Medicare.
Claim was filed to Medicare first and was denied.
(PE2) Expenses incurred after coverage terminated. Please
be enclosed documentation and remit payment
for covered services.

Please see enclosed documentation:

- 1) CMS 1500 form
- 2) Medicaid denial dated 5/25/07
- 3) Medicare denial dated 4/25/07
- 4) Information from Social Security (3pgs)
- 5) copy of ambulance call report.

Medicaid Appeals
SC Dept of Health and Human Services
Division of Appeals and Hearings
P O Box 8206
Columbia, SC 29202-8206



Aug. 24, 2007 1:03PM

PPS

PLEASE
DO NOT
STAPLE
IN THIS
AREANo. 6889 rev. 10-2005-2006
MEDICAD CLAIMS
P O BOX 8809

COLUMBIA, SC 29202-8809

HEALTH INSURANCE CLAIM FORM

PCA

1. MEDICARE MEDICAD CHAMPUS CHAMPVA		GROUP HEALTH PLAN (See item 1)		OTHER (See item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
DITIAH RASAIT		06 10 1925		7780363932	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)	
2109 ABERNATHEY DR		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		FLORENCE	
CITY		STATE		STATE	
FLORENCE		SC		FLORENCE	
ZIP CODE		TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
29505		(843) 665-5362		()	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			
9. OTHER INSURED'S POLICY OR GROUP NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment herein.)		13. INSURED'S DATE OF BIRTH	
		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (Date of Birth)		MM DD YY	
		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		MM DD YY	
16. INSURANCE PLAN NAME OR PROGRAM NAME		17. ID. NUMBER OF REFERRING PHYSICIAN		18. INSURED'S DATE OF BIRTH	
				MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?		21. INSURED'S DATE OF BIRTH	
		YES <input type="checkbox"/> NO <input type="checkbox"/>		MM DD YY	
22. MEDICAD RESUBMISSION ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		24. INSURED'S DATE OF BIRTH	
				MM DD YY	
25. FEDERAL TAX ID. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	
57-6000351		295599		YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		29. AMOUNT PAID		30. BALANCE DUE	
HOSPITAL-CAROLINA HOSPITAL-PAMPALICO HWY		415 00 00		415 00	
FLORENCE, SC 29501					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Denial or Creditals)		32. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE		33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE	
DIRECTOR GARY HORN		180 N. IRBY STREET, MSC-GG		180 N. IRBY STREET, MSC-GG	
		FLORENCE, SC 29501-3003		FLORENCE, SC 29501-3003	
34. SIGNATURE OF PATIENT OR AUTHORIZED PERSON		35. SIGNATURE OF PATIENT OR AUTHORIZED PERSON		36. SIGNATURE OF PATIENT OR AUTHORIZED PERSON	

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

No. 6889 P. 12

300512LBS 3000000004 MEDICARE
REBUTTANCE
NOTICE

PROVIDER #: 0258190001
PAGE #: 1 OF 2
DATE: 04/23/07
CHECK/EFT #: 300512155

The Centers for Medicare and Medicaid Services (CMS) is conducting the Medicare Contractor Satisfaction Survey (MCSS). If you have received a survey but have not yet completed it, we need your valuable feedback as soon as possible. If you have any questions please send an e-mail to mcps@cms.hhs.gov.

020721049826	ASS Y	HQA MAOT	
0.00	FR-27	250.00	0.00
0.00	FR-B3	15.00	0.00
0.00		265.00	0.00
0.00			NET
<hr/>			
ICN 0207106119180	ASS Y	HQA MAOT	
0.00	FR-27	400.00	0.00
0.00	FR-27	15.00	0.00
0.00		415.00	0.00
0.00			NET
<hr/>			
ICN 0207106119576	ASS Y	HQA MAOT	
0.00	DA-107	400.00	0.00
0.00	DA-107	5.00	0.00
0.00		405.00	0.00
0.00			NET
<hr/>			
ICN 0207107257964	ASS Y	HQA MAOT	
0.00	FR-204	200.00	0.00
0.00		200.00	0.00
0.00			NET
<hr/>			
ICN 0207107256050	ASS Y	HQA MAOT	
0.00	FR-22	250.00	0.00
0.00	FR-22	20.00	0.00
0.00		270.00	0.00
0.00			NET

GLASSARY: Group,	Reason, MDI, Remark and Adjustment Codes
PR	Patient Responsibility. Amount that may be billed to a patient or another payer.
DA	Other Adjustments.
B9	Services not covered because the patient is enrolled in a Medicare.
D9	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
109	This service/equipment/drug is not covered under the patient's current benefit plan. Payment is adjusted because this care may be covered by another payer per benefit plan.
204	Expenses incurred after coverage terminated.
22	
27	

04/25/07

125-76-7534T

Page 3 of 3

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

MEDHMS08 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/30/07
MEDSPROD MEDICARE COVERAGE ACTION:

NAME: DILLAH RASAU

HH NAME: DILLAH RASAU

RCP NUMBER: 7780363932

HH NUMBER: 101005318

ACTION TYPE: MAINTENANCE

SSN: 125-76-7534

APL STATUS:

ACTION DATE: 10/04/2004

MCN: 125767534M

VALIDATED BY: BUY IN

ON: 08/05/2007

PART A - BEGINNING DATE:

ENDING DATE:

BY:

PART B - BEGINNING DATE:

ENDING DATE:

BY: MMA

PART C - BEGINNING DATE: 07/01/2007

ENDING DATE:

BY: MMA

PART D - BEGINNING DATE: 06/01/2007

ENDING DATE:

BY: MMA

LOW INC- BEGINNING DATE: 06/01/2007 ENDING DATE: 12/31/2008 BY: MMA
SUBSIDY

UPDATED: USER ID: RENEH DATE: 06/12/07 SYSTEM ID: TTR1004 DATE: 08/27/07
ME900063 RECIPIENT RECORD FOUND
PF1->HELP PF3->NEXT SCR PF4->REFH PF10->PREV MENU PF13->FIELD HELP
PF16->BUY IN PF17->BENDEX INFO PF18->MMA01 PF19->COB01 PF21->HIST-

X digital 01/06

SSA will contact doctor

Renae Johnson has faxed
to her & she has her

number.

We just need to write that we are
handling & are in contact w/ Dr.
Bautista

of 8/29/07

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Jacobs</i>	DATE <i>8-31-07</i>
---------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOC NUMBER <i>000124</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Cleared 8/31/07 per Jan P. See attached Note.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>9-11-07</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.			



HUGH K. LEATHERMAN, SR.

SOUTH CAROLINA STATE SENATE
DISTRICT 31, FLORENCE
AND DARLINGTON COUNTIES

COMMITTEES
Chairman, Finance
Chairman, Operations and Management
Ethics
Interstate Cooperation
Labor, Commerce and Industry
Rules
State House
Transportation

111 GRESSETTE SENATE OFFICE BUILDING
COLUMBIA, SOUTH CAROLINA 29202
(803) 212-6640

FLORENCE ADDRESS
1817 Pineland Avenue
Florence, South Carolina 29501
(843) 667-1152

August 27, 2007

Emma Forkner, Director
Department of Health & Human Services
1801 Main Street
Columbia, South Carolina 29201

Dear Ms. Forkner:

I am enclosing herewith a copy of a letter, with attachments, that I recently received from Shareefa Bautista, the daughter and caregiver of Rasaul Dillah. As you can see, it appears that Ms. Bautista is having difficulty in getting her father's records to reflect that he had no insurance during 2006 and that his Medicare Part B coverage became effective April 1, of this year.

I would very much appreciate it if you would ask your staff to look into this matter and see that Mr. Dillah's records are corrected and that provider invoices are paid if appropriate.

Thank you for your assistance in this matter.

Very truly yours,

A handwritten signature in blue ink, appearing to read "H. K. Leatherman, Sr.", is written over a horizontal line.

Hugh K. Leatherman, Sr.
HKL:dsm

Enclosure

cc Ms. Shareefa Bautista
13-DI/1

RECEIVED

AUG 29 2007

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Spoke w/ Brian in
San Leandro via pri-
vate to close -
No written response
necessary.

8/21 

Would this be an
elig. issue or more
modest ones?
Thank you both!

per
8/29

The Honorable Hugh K. Leatherman
SC Senate
PO Box 142
Columbia SC 29202

Sharcefa Bautista
2109 Abernathy Dr
Florence SC 29505
Tel: 843-664-0765(home)
Tel: 843-669-5162 ext 347
August 24, 2007

Dear Mr. Leatherman:

I am the caregiver for my dad Rasaul Dillah who resides with me at the above address. I am not sure if you could help me or if you could direct me to the right agency that will. My dad is having problems with Medicare and Medicaid office. He did not work long enough in the United States to be eligible for Medicare, he only worked 5 years before he had heart surgery in 1991. He has been living with since 2004, before he resided with my sister in New York. He was on Medicaid last year only. This year he became eligible for Medicare Part B only effective 4-1-2007 since he is now a dialysis patient. The state pays for his premium for Part B only. I have been to Medicaid office several times, called and spoken to his case worker Barbara Ford (843-669-3354 ext 254) to try to get them to update his records that for 2006 he did not have Medicare Part B. She has really tried to get them to update but the Columbia office is not doing what they are suppose to do. All his claims that got paid by Medicaid office last year, Medicaid is recouping their money telling providers that he has other insurance, and he did not for last year Jan to Dec 2006. I do not know what else to do to help my dad. He is now getting bills from providers and he has limited income, he is not eligible for Social Security benefits or SSL.

I am sending proof where I contacted offices and faxed them information needed to get records updated as off today, and nothing has been done. Medicaid office still show he has other insurance for last year and I am sending copy of his medicare card showing his effective date. I spoke to Vivian Buford responsible for transport services in Florence area. The EMS said they could not do anything to get bill paid, I also spoke to provider today. Sending you copy of letter they sent my dad that he was responsible for his bill where Medicaid should be paying for this.

Please advise me further what I could do to get this resolved.

Sharcefa Bautista
Sharcefa Bautista

Aug. 24, 2007 1:01 PM

No. 6889 P. 3



PHYSICIAN PRACTICE SOLUTIONS, LLC

PO BOX 100523
217 DOZIER BLVD, STE 100
FLORENCE, SC 29501

PHONE: (843) 669-5162 or
(843) 669-9255
FAX: (843) 667-4573

Date: ~~8-10-07~~

No. of sheets to follow: 9

To: Vivian Buffett

From: SHAREEFA BAUTISTA

Company: Mediaryl

Company: FLORENCE RADIOLOGY

Fax #: 803-255-8220

Fax #: (843) 667-4573

Phone #:

803-898-3902

Phone #:

(843) 669-5162 EXT 347
(800) 741-6920 ext 347

EMAIL: sbautista@physicianpracticesolutions.com

☒ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

Comments

Sending you proof where Medicare shows coverage started 4/1/07. Columbia Office for Mediaryl has wrong information - causing all his claims to get reprocessed by providers. See Medicare claim.

Shanell

~~Canceled~~
Vivian Buffett
Mediaryl
803-898-3902

fax 803-255-8220

Coding Disclaimer: Physician Practice Solutions, LLC has made every effort provided. Absolute accuracy cannot be guaranteed, however. Given the ever surrounding the health care industry, it is recommended that carriers be questioned, or any significant changes to current reporting practices, prior to it made available with the understanding that Physician Practice Solutions, LLC advice.

Has someone working on Medicare

Medicare claim not processing down

Step 1
6/25/07
803-3035

Still waiting on update on 6/25/07

803-255-8220
803-898-3902

Aug. 24. 2007 1:01PM PPS

No. 6889 P. 4

SOUTH CAROLINA
DEPARTMENT OF MOTOR VEHICLES
DRIVER'S LICENSE


BAUTISTA SHANE ADILLAH
2108 ABERNATHY DR
FLORENCE SC 29505

DL#: 007404398
Expires: 12-02-2016

Class: D Hgt: 5-02 Wgt: 157
Sex: F DOB: 12-02-1965
Issued: 01-17-2005 21021 B 1

Shane M. Bautista
[Signature]

Restrictions: A





PHYSICIAN PRACTICE SOLUTIONS, LLC

PO Box 100523
217 DOZIER BLVD, STE 100
FLORENCE, SC 29501

PHONE: (843) 669-5162 or
(843) 669-9255
FAX: (843) 667-4573

Date: 7-11-07

No. of sheets to follow: 10

To: Bubba Ford

From: SHARKEFA BAUTISTA

Company: DHHS in FLor

Company: FLORENCE RADIOLOGY

Fax #: 629-8192

Fax #: (843) 667-4573

Phone #: 669-3354

Phone #: (843) 669-5162 EXT 347
(800) 741-6920 ext 347

EMAIL: sbautista@physicianpracticesolutions.com

☒ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

Comments

Good morning hope you are well.
My dad got H1N1 in the mail
yesterday after I saw you. I don't
know what else to do. Medicare was
fired, they got the denial and Medicaid
still does not want to pay. See rejections
from Medicare and Medicaid
Please help. Have a blessed day.

Shamek

Coding Disclaimer: Physician Practice Solutions, LLC has made every effort to ensure accuracy of the information provided. Absolute accuracy cannot be guaranteed, however. Given the evolving nature of the rules and regulations surrounding the health care industry, it is recommended that carriers be questioned regarding any new information presented, or any significant changes to current reporting practices, prior to implementation. This information is made available with the understanding that Physician Practice Solutions, LLC is not engaged in rendering legal advice.

FLORENCE COUNTY EMS

180 N. IRBY STREET, MSC-GG
FLORENCE, SC 29501

Medicaid denied appeal.

Medicare denied payment.

*bill is non-issue
responsibility.*

RASAUJ DILLAH
2109 ABERNATHEY DR
FLORENCE, SC 29505

43022
295599
03/16/2007
2109 ABERNATHEY DR
HOSPITAL-CAROLINA HOSPITAL
786.52
786.05

Patient Name: RASAUJ DILLAH
Insurance: MEDICAID CLAIMS

DESCRIPTION OF CHARGES	IT PRICE	AMOUNT
ALS BASE-EMERGENCY	A0427 1.0	300.00
MILEAGE	A0425 3.0	15.00
OXYGEN SUPPLIES	A0422 1.0	50.00
EKG SUPPLIES	A0392 1.0	50.00

Total Charges 415.00

DESCRIPTION OF PAYMENT	RECEIPT	PAYMENT DATE	AMOUNT
REJECTED-MEDICAID	4986521	07/02/2007	0.00
REJECTED-MEDICAID	4977272	06/18/2007	0.00
REJECTED-MEDICAID	4983501	06/04/2007	0.00
REJECTED-MEDICAID	4964446	06/29/2007	0.00
Total All Other Payments			<u>0.00</u>
		Total Credits	0.00

PLEASE PAY THIS AMOUNT => **\$415.00**

^DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT^

Patient Name: DILLAH, RASAUJ
Patient Number: 43022

Call Number: 295599
Current Date: 07/06/2007

Amount Due: \$415.00
Amount
Enclosed \$

WE HAVE RECEIVED PAYMENT FROM YOUR INSURANCE COMPANY. THE BALANCE SHOWN ON THIS STATEMENT
REFLECTS THE CO-PAYMENT AMOUNT WHICH IS YOUR RESPONSIBILITY.



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

July 3, 2007

Susan B. Bowling
Acting Director

Florence County EMS
180 North Irby Street, MSC-GG
Florence, South Carolina 29501-3003

RE: Appeal request in the matter of Florence County EMS v. SCDHHS
Recipient: Rasaul Dillah, ID# 7780363932
Appeals' File #07-U-083

Dear Ms. Stewart:

Enclosed please find your submission in the above referenced appeal matter.

Also enclosed is a copy of the South Carolina Medicaid appeals' process found in the South Carolina Medicaid Provider Manual. As you can see, there is no provision for a review, or reconsideration, of rejected claims or partial payments. The South Carolina Medicaid appeal process is a formal evidentiary hearing held here in Columbia, South Carolina. As the policy states, providers should make every effort to work with their program representative to resolve issues in dispute before requesting an appeal, and then only if they desire an evidentiary hearing.

If you desire a hearing, please follow the Manual instructions attached.

If you have any questions, you may call me at 1-800-763-9087.

Sincerely,

Vastine G. Crouch

Vastine G. Crouch
Director
Division of Appeals and Hearings

Enclosure

Division of Appeals
P. O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2600 Fax (803) 255-8206

XXX Provider Manual

01/01/06

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS**

APPEALS

DHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in S.C. Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

An administrative appeal is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should work with their program representative in an effort to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of DHHS, a provider wishing to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Subsequent hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

Current Date: 6/01/07
 Medicaid Recipient Name: **Rosaul Dillah**
 Medicaid Recipient Number: 7780363932

Provider Name: **Renewed Liberty EMS**
 Provider Number: **AB0030**
 Contact Person: **K. Stewart**
 Telephone Number: **843 668 3011**
 Signature of Person Requesting Appeal: **Kathryn Stewart**
 FAX Number: **843 676 8795**

Data on Claims to be Appealed

<u>Providers</u>	<u>Claim</u>	<u>Service</u>	<u>Proc</u>	<u>Amt</u>	<u>Recipient</u>	<u>Recipient</u>
<u>Ref. #</u>	<u>Ref #</u>	<u>Dates</u>	<u>Codes</u>	<u>Billed</u>	<u>ID #</u>	<u>Name</u>
295599	ME	03/16/07	A0427	400.00	7780363932	P. Dillah
	Levick	03/16/07	A0425	15.00	"	"

Explain of why you like an Appeal:
 Medicaid denied (953) Possible Medicare buy-in file to Medicare.

Claim was filed to Medicare first and was denied.
 (Per) Expenses incurred after coverage terminated. Please
 be enclosed documentation and remit payment
 per covered services.

Please see enclosed documentation:

- 1) CMS 1500 form
- 2) Medicaid denial dated 5/25/07
- 3) Medicare denial dated 4/25/07
- 4) Information from Social Security (3pgs)
- 5) copy of ambulance call report.

Medicaid Appeals
 SC Dept of Health and Human Services
 Division of Appeals and Hearings
 P O Box 8206
 Columbia, SC 29202-8206



No. 6889 - rev. 10-20-00

P O BOX 8809

COLUMBIA, SC 29202-8808

HEALTH INSURANCE CLAIM FORM

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE		MEDICAID		CHAMPUS		CHAMPVA		GROUP HEALTH PLAN		FECA BLK LUNG	
(Medicare #)		(Medicaid #)		(Sponsor's SSN)		(VA File #)		(SSN or ID)		(ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)											
DILLAR, BASAULT											
3. PATIENT'S BIRTH DATE											
06 10 1995											
4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
7780363932											
5. PATIENT'S ADDRESS (No. Street)											
2109 ABERNATHY DR											
6. PATIENT'S RELATIONSHIP TO INSURED											
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
7. INSURED'S ADDRESS (No. Street)											
2109 ABERNATHY DR											
8. PATIENT'S STATUS											
Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>											
9. EMPLOYMENT? (CURRENT OR PREVIOUS)											
Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>											
Student <input type="checkbox"/> Other <input type="checkbox"/>											
10. IS PATIENT'S CONDITION RELATED TO:											
a. EMPLOYMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
11. INSURED'S POLICY GROUP OR FECA NUMBER											
29505											
12. INSURED'S DATE OF BIRTH											
MM DD YY											
13. EMPLOYER'S NAME OR SCHOOL NAME											
14. INSURANCE PLAN NAME OR PROGRAM NAME											
15. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
16. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
17. INSURED'S POLICY GROUP OR FECA NUMBER											
18. INSURED'S DATE OF BIRTH											
MM DD YY											
19. EMPLOYER'S NAME OR SCHOOL NAME											
20. INSURANCE PLAN NAME OR PROGRAM NAME											
21. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
22. INSURED'S POLICY GROUP OR FECA NUMBER											
23. INSURED'S DATE OF BIRTH											
MM DD YY											
24. EMPLOYER'S NAME OR SCHOOL NAME											
25. INSURANCE PLAN NAME OR PROGRAM NAME											
26. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
27. INSURED'S POLICY GROUP OR FECA NUMBER											
28. INSURED'S DATE OF BIRTH											
MM DD YY											
29. EMPLOYER'S NAME OR SCHOOL NAME											
30. INSURANCE PLAN NAME OR PROGRAM NAME											
31. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
32. INSURED'S POLICY GROUP OR FECA NUMBER											
33. INSURED'S DATE OF BIRTH											
MM DD YY											
34. EMPLOYER'S NAME OR SCHOOL NAME											
35. INSURANCE PLAN NAME OR PROGRAM NAME											
36. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
37. INSURED'S POLICY GROUP OR FECA NUMBER											
38. INSURED'S DATE OF BIRTH											
MM DD YY											
39. EMPLOYER'S NAME OR SCHOOL NAME											
40. INSURANCE PLAN NAME OR PROGRAM NAME											
41. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
42. INSURED'S POLICY GROUP OR FECA NUMBER											
43. INSURED'S DATE OF BIRTH											
MM DD YY											
44. EMPLOYER'S NAME OR SCHOOL NAME											
45. INSURANCE PLAN NAME OR PROGRAM NAME											
46. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
47. INSURED'S POLICY GROUP OR FECA NUMBER											
48. INSURED'S DATE OF BIRTH											
MM DD YY											
49. EMPLOYER'S NAME OR SCHOOL NAME											
50. INSURANCE PLAN NAME OR PROGRAM NAME											
51. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
52. INSURED'S POLICY GROUP OR FECA NUMBER											
53. INSURED'S DATE OF BIRTH											
MM DD YY											
54. EMPLOYER'S NAME OR SCHOOL NAME											
55. INSURANCE PLAN NAME OR PROGRAM NAME											
56. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
57. INSURED'S POLICY GROUP OR FECA NUMBER											
58. INSURED'S DATE OF BIRTH											
MM DD YY											
59. EMPLOYER'S NAME OR SCHOOL NAME											
60. INSURANCE PLAN NAME OR PROGRAM NAME											
61. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
62. INSURED'S POLICY GROUP OR FECA NUMBER											
63. INSURED'S DATE OF BIRTH											
MM DD YY											
64. EMPLOYER'S NAME OR SCHOOL NAME											
65. INSURANCE PLAN NAME OR PROGRAM NAME											
66. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
67. INSURED'S POLICY GROUP OR FECA NUMBER											
68. INSURED'S DATE OF BIRTH											
MM DD YY											
69. EMPLOYER'S NAME OR SCHOOL NAME											
70. INSURANCE PLAN NAME OR PROGRAM NAME											
71. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
72. INSURED'S POLICY GROUP OR FECA NUMBER											
73. INSURED'S DATE OF BIRTH											
MM DD YY											
74. EMPLOYER'S NAME OR SCHOOL NAME											
75. INSURANCE PLAN NAME OR PROGRAM NAME											
76. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
77. INSURED'S POLICY GROUP OR FECA NUMBER											
78. INSURED'S DATE OF BIRTH											
MM DD YY											
79. EMPLOYER'S NAME OR SCHOOL NAME											
80. INSURANCE PLAN NAME OR PROGRAM NAME											
81. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
82. INSURED'S POLICY GROUP OR FECA NUMBER											
83. INSURED'S DATE OF BIRTH											
MM DD YY											
84. EMPLOYER'S NAME OR SCHOOL NAME											
85. INSURANCE PLAN NAME OR PROGRAM NAME											
86. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
87. INSURED'S POLICY GROUP OR FECA NUMBER											
88. INSURED'S DATE OF BIRTH											
MM DD YY											
89. EMPLOYER'S NAME OR SCHOOL NAME											
90. INSURANCE PLAN NAME OR PROGRAM NAME											
91. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
92. INSURED'S POLICY GROUP OR FECA NUMBER											
93. INSURED'S DATE OF BIRTH											

APPROVED OMB-0838-0008 FORM CMS-1500 (12-80), FORM RRB-1500,

APPROVED OMB-1215-0025 FORM OWC9-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PROVIDER NAME AND ADDRESS
 FLORENCE COUNTY
 FLORENCE COUNTY FINANCE
 100 N. IRBY ST MSC-08
 FLORENCE
 SC 29501

PROVIDER ID.	000000111	DEPT OF HEALTH AND HUMAN SERVICES	SOUTH CAROLINA MEDICAID PROGRAM	PROFESSIONAL SERVICES	REMITTANCE ADVICE	05/25/2007	PAYMENT DATE	PAGE	2
--------------	-----------	-----------------------------------	---------------------------------	-----------------------	-------------------	------------	--------------	------	---

No. 6889 P. 12

300512153 300000084

[illegible]

PROXY NUMBER #: 0258190001
PAGE #: 1 OF 2
DATE: 04/23/07
CHECK/EFT #: 398512155

The Centers for Medicare and Medicaid Services (CMS) is conducting the Medicare Provider Satisfaction Survey (MPSS). If you have received a survey but have not yet completed it, we need your valuable feedback as soon as possible. If you have any questions please send an e-mail to mpss@cms.hhs.gov.

[illegible]

ICN	0207106119570	ASE Y	HQA MA01
0.00	0.00 DA-109	408.00	0.00
0.00	0.00 DA-109	15.00	0.00
0.00	0.00	415.00	0.00
NET			0.00

ICN	0207107207960	ASE Y	HQA MA01
0.00	0.00 PR-204	200.00	0.00
0.00	0.00	0.00	0.00
NET			0.00

ICN	0207107236050	ASE Y	HQA MA01
0.00	0.00 PR-22	250.00	0.00
0.00	0.00 FR-22	23.00	0.00
0.00	0.00	275.00	0.00
NET			0.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	3	1560.00	0.00	0.00	0.00	1560.00	0.00	0.00	0.00

6 PR 0A B7 109 284 22 27	GROSSARY: Group, Reason, NOA, Remark and Adjustment Codes Patient Responsibility. Amount that may be billed to a patient or another payer. Other Adjustment. Services not covered because the patient is enrolled in a Medicare. Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. This service/equipment/drug is not covered under the patient's current benefit plan. Payment adjusted because this care may be covered by another payer per benefit. Expenses incurred after coverage terminated.
---	--

02/25/07

HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

NAME OF BENEFICIARY
RASAUL DILLAH

HASNUT MEDICARE CLAIM NUMBER

১৫.

MALE:

IV. LITERATURE

125-16-1-34

1

MEDICAL (PART B)

04-01-2007

BENEFITS ONLY

04-01-2008
AL (PARTIAL)
FITS ONLY
Rozand P. P. P.

食藥產

THIS IS YOUR MEDICARE CARD. IT SHOWS
IF YOU HAVE HOSPITAL INSURANCE,
MEDICAL INSURANCE OR BOTH. IT IS FOR
YOUR USE ONLY. SHOW YOUR CARD WHEN
YOU RECEIVE HEALTH SERVICES. ON ANY
CLAIMS, BILLS OR CORRESPONDENCE BE
SURE TO USE YOUR NAME AND CLAIM
NUMBER EXACTLY AS SHOWN ON THIS
CARD.

...night 295

AUTO 3-DIGIT

059614

06F 141
0607 RE 06F 141

CAO DILLAH
RASUL DILLAH DRIVE
PENNATHY DRIVE

7109 ABERNATHY DRIVE
SPRINGFIELD SC 29505-6714

0607 1 K 125767534M

Social Security Administration Retirement, Survivors and Disability Insurance Notice of Disapproved Claim

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: May 15, 2007
Claim Number: 125-76-7534T

00164 NC0477 N1 1260

RASAU, DILLAH
2109 ABERNATHY DRIVE
FLORENCE, SC 29503-6714
[REDACTED]

We are writing to tell you that you do not qualify for Medicare.

Why You Cannot Qualify for Medicare

You did not work long enough under Social Security to qualify for Medicare.

Work under Social Security is figured in credits. Please read the enclosed pamphlet, "How You Earn Social Security Credits," which explains how the credits are earned.

For you to qualify for Medicare, you needed to have earned 36 credits. You earned 16 credits. These figures are based on your date of birth, June 10, 1925.

Other Social Security Benefits

You are not entitled to any other Social Security benefits based on the application you filed. In the future, if you think you may be entitled to benefits, you will need to apply again.

Enclosure(s):
Pub 05-10072
Pub 05-10058

C

See Next Page

125-76-7534T

Page 3 of 3

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

MEDHMS08 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/30/07
MEDSPROD MEDICARE COVERAGE ACTION:

NAME: DILLAH RASAUH HH NAME: DILLAH RASAUH
RCP NUMBER: 7780363932 HH NUMBER: 101005318 ACTION TYPE: MAINTENANCE
SSN: 125-76-7534 APL STATUS: ACTION DATE: 10/04/2004
MCN: 125767534M VALIDATED BY: BUY IN ON: 08/05/2007

PART A - BEGINNING DATE:	ENDING DATE:	BY:
PART B - BEGINNING DATE: <u>01/01/2007</u>	ENDING DATE: _____	BY: MMA
PART C - BEGINNING DATE: 07/01/2007	ENDING DATE: _____	BY: MMA
PART D - BEGINNING DATE: 06/01/2007	ENDING DATE: _____	BY: MMA
LOW INC- BEGINNING DATE: 06/01/2007	ENDING DATE: 12/31/2008	BY: MMA
SUBSIDY		

UPDATED: USER ID: RENEH DATE: 06/12/07 SYSTEM ID: TTR1004 DATE: 08/27/07
ME900063 RECIPIENT RECORD FOUND
PF1->HELP PF3->NEXT SCR PF4->REFH PF10->PREV MENU PF13->FIELD HELP
PF16->BUY IN PF17->BENDEX INFO PF18->MMA01 PF19->COB01 PF21->HIST-

X

01/01/07

SSA will contact dates

Renae Johnson has told Paul
to her & she has her

numbers.

We just need to note that we are
handling & are in contact w/ Jt.
Bautista

08/29/07

MEDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/30/07
 MEDSPROD RECIPIENT INFORMATION ACTION:

MEMBER PERIOD START: 08/26/07 END: PAGE: 0001

NAME: DILLAH RASAUL HH NAME: DILLAH RASAUL

RCP NUMBER: 7780363932 HH NUMBER: 101005318 ACTION TYPE: MAINTENANCE

SSN: 125-76-7534 VC: V APL STATUS: ACTION DATE: 10/04/04

PRIMARY INDIVIDUAL: APL CO: 21 WORKER ID: PSIEG LOCATION: 001

2109 ABERNATHY DR SSCN: 125767534M RRN:

RACE: 08 SEX: M MARITAL STATUS: W

TPL INSURANCE: N RELATION: SELF

FLORENCE SC 29505- DOD:

CORRECT RCP NUMBER: LTV ARRANGEMENT: HOME INCOME TRUST:

PROVIDER:

BG	BEG	END	BENEFITS	QMB	RETRO	% OF	POV
S	NUMBER	ELIG	ELIG	PCAT	QCAT	TYPE	IND IND LEVEL SPONSOR
-	38578088	02/01/2006		32	10	FULL	N Y .44
-	38578088	11/01/2004	02/01/2006	32	10	FULL	Y Y .44
-	38578088	10/01/2004	11/01/2004	32	10	FULL	N Y .44

UPDATED: USER ID: RENEH DATE: 06/06/07 SYSTEM ID: BUY1000 DATE: 06/27/07
 ME900063 RECIPIENT RECORD FOUND

PF2->HH BG PF3->HH MBR DTL PF4->REFH PF5->ELD02 PF6->RETURN PF7->PREV

PF8->NEXT PF9->HH NOTES PF15->RCP SEARCH PF17->ELD00 PF18->HH MBR BGS