

2020

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM DARLINGTON COUNTY
Court of Common Pleas
Honorable J. Michael Baxley
Circuit Court Judge

CIVIL ACTION NO: 2010-CP-16-0332
TRACKING NO: 2011203391

Pee Dee Health Care, P.A., ...Appellant,

v.

Hugh S. Thompson, III, Louise T. Dailey, as Personal
Representative of the Estate of Hugh S. Thompson, ...Respondent.

RECORD ON APPEAL

Vol 2

Counsel of Record for Appellant:

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Counsel of Record for Respondent:

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And

Jay James, Esquire
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SC Court of Appeals

INDEX	PAGE
Court Orders	
Order Disqualifying Plaintiff's Counsel Tony R. Megna dated April 15, 2011	4
Order Denying Plaintiff's 59(e) Motion for Reconsideration of Order Disqualifying Counsel and Quashing All Motions, Subpoenas, and Filings Signed Only by Disqualified Tony R. Megna dated August 12, 2011	13
Summary Judgment Order in favor of Defendant dated August 29, 2011 and filed September 1, 2011	18
Order dated September 28, 2011 and filed October 4, 2011, Dismissing Plaintiff's Motion to Reconsider the Order Granting Summary Judgment	35
Order of John Cannon Few, C.J. Denying Respondent's Motion to Dismiss Appeal on Merits as Untimely and Dismiss all Interlocutory Appeals as MOOT dated January 9, 2012	37
Decisions	
Letter from CMS dated October 05, 2007 Re: Medicare Appeal Decision	39
Judge Joe Decision on First Choice Appeal dated January 22, 2008	89
Judge Dean C. Metry Decision: ALJ Appeal of Pee Dee Health Care dated March 14, 2008	101
Pleadings	
Statement of Creditor's Claim filed in Probate Court April 14, 2010	112
Plaintiff's Complaint filed May 20, 2010 [includes Letter to Judge Lawson from Benjamin R. Matthews dated May 20, 2010 with Amended Claim of PDHC filed in Probate Court on May 20, 2010]	163
Defendant's Answer filed June 17, 2010	183

INDEX	PAGE
Plaintiff's Motion For Summary Judgment December 9, 2010	196
Defendant's Motion to Amend Answer dated December 10, 2010	198
Plaintiff's Response to Disqualification Motion dated March 11, 2011	200
Defendant's Counter Motion for Summary Judgment filed May 20, 2011 (with all exhibits including Judge Metry Decision dated March 14, 2008)	249
Supplemental Exhibit Supporting Defendant's Counter Motion for Summary Judgment filed May 26, 2011 (together with attachment Medicare Appeals Counsel Decision dated October 6, 2008)	279
Defendant's Reply in Support of Summary Judgment filed July 11, 2011	289
Motion for Protective Order by Turner Padget dated August 9, 2011	304
Plaintiff's Reply to Motion for Protective Order dated August 10, 2011	311
Notice of Appeal of the Order dated August 12, 2011 regarding the disqualification of Tony R. Megna as counsel which was received by the Court of Appeals on August 24, 2011 and filed with the Darlington Clerk of Court on October 13, 2011	329
Plaintiff's Notice of Appeal of the Order of Summary Judgment dated October 28, 2011	349
Respondent's Motion to Dismiss Appeal dated November 14, 2011	356
Reply to Respondent's Motion to Dismiss Appeal received November 22, 2011	365
Respondent's Reply in Support of Motion to Dismiss Appeal December 1, 2011	370
Amended Reply To Respondent's Motion to Dismiss Appeal December 14, 2011	375
Affidavit of James Goodson	381
Affidavit of Warren Mark Matthews, Sr.	382
Affidavit of Dr. James McInnis	384

INDEX	PAGE
Affidavit of Katherine Noyes	386
Affidavit of Eileen S. Segers, RN	387
Affidavit of Barbara Stokes, RN	388
Affidavit of Kim Weatherford	389
Transcripts	
Transcript of Motion Hearing dated March 16, 2011	390
Transcript of Motion Hearing dated July 21, 2011	431
Exhibits	
Letter from the Department of Health and Human Services to Dr. Eugene Laurent (Thompson Exclusion Letter) dated March 11, 1996	489
Letter from South Carolina Board of Medical Examiners notifying Dr. Thompson of the reinstatement of his license dated April 14, 1998	490
Letter from Medicare Palmetto Government Benefits Administrators to Dr. Hugh S. Thompson dated June 12, 1998	505
Thompson Medicare Application for Fowler dated June 19, 1998 [Respondent's #10 in their Designation of Matters]	491
Letter from PGBA to Dr. Thompson dated August 31, 1998 assigning provider number	508
Letter from Medicare Palmetto Government Benefits Administrators to Dr. Hugh S. Thompson dated September 14, 1998	509
Letter from Health Care Financing Administration to Dr. Thompson (Regarding Reassignment of Benefits) dated December 8, 1998 to Dr. Thompson	511
Letter from DHHS to Dr. Thompson dated June 20, 2002 approving reinstatement of eligibility as a Medicare provider	512

INDEX	PAGE
Letter from Centers of Medicare and Medicaid Services dated May 30, 2007 Re: Overpayment	513
Letter to PGBA dated June 07, 2007 re: Request for Payment Plan	516
Letter to Medicare from Nexsen Pruet dated June 15, 2007 re: Request for Redetermination and Withhold Objection	519
Email to Tony Megna from Mark Matthews dated July 10, 2007 [Respondent's #12 in their Designation of Matters]	523
Email from Tony Megna to Dean Banks dated July 11, 2007 re: Redetermination letter from Pee Dee Health Care to PGBA	524
FirstChoice (Nexsen Pruet as counsel) dated October 17, 2007	526
Jay James supplemental production response letter July 09, 2010	528
Tony R. Megna Letter dated July 8, 2011 to Trial Judge	530
Letter from Turner Padget to Kim Weatherford dated July 15, 2011	545
Email from Tony Megna to Brandon Hylton dated July 20, 2011	548
Letter from Turner Padget to Tony Megna dated July 25, 2011	550
Letter from Tony Megna to Judge Baxley dated July 25, 2011	552
Email from Tony Megna to Renee Josey dated July 26, 2011	554
Letter from Tony Megna to Judge Baxley dated July 27, 2011 with attached subpoenas of Renee Josey, Jay James, Desa Ballard, Kenneth Woodington, Brad Hylton, and Celeste Jones	557
Letter from Turner Padget with Consent Order for Substitution of Counsel to Ms. Virginia Crocker of the South Carolina Workers' Compensation Commission dated August 3, 2011	581
Judge Baxley Letter dated August 12, 2011 Announcing Summary Judgment [Respondent's #23 in their Designation of Matters]	584
Court of Appeals Letter regarding the separation of appeals dated December 7, 2011	586

INDEX	PAGE
Reassignment of Benefits (Form 855) completed by Dr. Thompson for PDHC [Respondent's #11 in their Designation of Matters]	588
Educational/Employment Background (Diplomas, Certifications, Hearings before the Medical Board of S.C.) of Dr. Hugh S. Thompson	590
Summary of Events and Observations of Hugh S. Thompson, MD obtained from FirstChoice [Respondent's #9 in their Designation of Matters]	628
South Carolina Uniform Managed Care Provider Credentialing Application of Dr. Thompson	641
Envelope from Nexsen Pruet addressed to PGBA marked HAND DELIVERED	686
Certificate of Counsel	716
Certificate of Service	717

1 didn't do that. They waited a decade. More than a
2 decade. But they had constructive knowledge the day he
3 went to work for them. And, even forgetting the statute
4 of limitations, if they have constructive knowledge,
5 which the federal judge has said, they have constructive
6 knowledge that he was lacking credentials from day one,
7 they could have stopped all of these damages. They
8 could have sat him down and said, oh, we have
9 constructive you are not credentialed. Quit seeing
10 patients until we get you credentialed. They didn't
11 mitigate their damages, but they should have known, and
12 knowing what they should have known, they could have
13 mitigated these damages. That's is also a point raised
14 in our Memorandum, Judge. This could have all been
15 avoided if they had done what the federal law and what
16 the South Carolina Common Law requires them to do.

17 Judge, the plaintiffs have plead some twenty
18 different causes of action, but other than the
19 conversion claim, the civil conspiracy claim, and the
20 contractual interference claim, justifiable reliance
21 doesn't seem to be as obvious of a component. It still
22 may be a component of the contractual interference
23 claim. But, those three claims, as I pointed out in our
24 Memorandum just don't fit these facts. We have not ---
25 This defendant has not converted anything that will

1 lawfully belong to these plaintiffs. If this Medicare
2 benefit that they received was converted, they had to be
3 lawfully entitled to it, and they were lawfully entitled
4 to it. That has already been adjudicated. Civil
5 conspiracy, they alleged that the conspiracy was between
6 the decedent and his own estate. That is not possible.
7 They allege that the contractual interference is between
8 the decedent and the Medicare program. Well, their
9 relationship to Medicare, this government entitle
10 program is not a contract. And there is no evidence to
11 suggest that even if it is a contract, that we
12 interfered.

13 Judge, this litigation as you can tell has been
14 tortuous and expensive for these two folks sitting back
15 here. And it is against an estate of modest and limited
16 value. And our Supreme Court has said, and as pointed
17 out in our memorandum in the standard of review and the
18 Corley case from 1984, --- I just wanted to read a few
19 quotes.

20 In the Corley case from 1984, our Supreme Court
21 said. The trial court is not required to single out
22 some morsel of evidence to create an issue of fact that
23 is not genuine.

24 Also the Supreme Court case in the Fabri case,
25 which is also cited in our Memorandum said. The purpose

1 of summary judgment is to expedite the disposition of
2 cases, not required to services of a fact finder.

3 Judge, this case is right for summary judgment.
4 For the defendants, there is no point in further
5 litigating issues that have already been adjudicated by
6 this plaintiff, to finality that are despositive in your
7 court.

8 Thank you.

9 **THE COURT:** Thank you. And, now, in reply, Mr.
10 Megna.

11 **MR. MEGNA:** Well, first of all my main office is
12 in Columbia, and I have an office here and in Atlanta.
13 And quite frankly these documents because the court sits
14 here in Darlington were filed by Mr. Matthews and other
15 people on staff in my office, with my full knowledge.
16 You know, for them to make implications is just
17 ridiculous. And they are right about one thing. I do
18 work late, I work all kind of hours, and I am certainly
19 not going to say otherwise. And they can call it what
20 they want. But when we got these documents, we knew
21 what we had. We had a genuine reason to file summary
22 judgment based on the documents and the answers they
23 provided and we did so.

24 They still have not identified, to this court, a
25 single duty that we owe the defendant under federal law.

1 Not a single duty. The statutes that they refer to go
2 to the duty that Medicare imposes upon the plaintiff.
3 We did everything we could to say that Dr. Thompson nor
4 I, nor Pee Dee Health Care, were responsible. They have
5 twisted and turned that into somehow with nebulously
6 saying that we had a duty. The Court has got to find
7 the core of the duty. Where is the duty? Federal law?
8 What federal law, did he point to, what specific federal
9 law, did he point to that said, we have that duty, not
10 to Medicare, to Dr. Thompson. We are not talking Dr.
11 Thompson's what he owed Medicare. We are talking about
12 what we paid on behalf of Dr. Thompson's behalf so there
13 was conversion. He was paid twice. We paid him for his
14 services. The documents show that he reassigned what he
15 got for those services to us, and then we repaid them
16 back to Medicare again.

17 As far as not having any statements by Dr.
18 Thompson, the same case law that he cited --- I won't go
19 over it again. Mr. Josey, cited --- said, that a
20 person is responsible, particularly an informed
21 intelligent person. And he is, was an informed
22 intelligent person for what he signed. Exhibit A,
23 number 4, and he signed this. Neither the individual
24 practitioner, nor any owner, director, officer, an
25 affiliate, an employee of the company. We all have

1 Affidavits to that effect. Or any contractor retained
2 by the company currently subject to sanction under the
3 Medicare/Medicaid program, or disbarment, suspension or
4 exclusion under any other federal agency program, or
5 likewise evident by providing services to Medicare
6 beneficiaries. Signed by Hugh S. Thompson. June 19,
7 1998. He made that statement within three months of
8 coming to our office. Three months.

9 Dr. Thompson, already part of the record on appeal
10 --- I'm sorry, the record before this court --- I'm
11 sorry. Just one second. I just had it here. I
12 apologize.

13 On September 14, 1998, a month before Dr. Thompson
14 comes to work for us, Medicare sent Dr. Thompson a
15 request, a specific request on page 2, that he provide
16 Medicare with a copy of his reinstatement. He never
17 showed it to us. Exhibit FF.

18 On August 31, 1998, Medicare sent a letter to Dr.
19 Thompson, Dr. Fowler, Exhibit W, reassigning Medicare
20 billing to Dr. Fowler's office. Medicare was sent to
21 the decedent. They did the same thing, signed for by
22 Ms. Kelly at First Choice. He gets another letter on
23 September 14, 1998, saying the same thing. And unknown
24 to the plaintiff, three times --- three times, he has
25 received from Medicare letters saying please, send us

1 information about your disbarment. March 11, 1996,
2 Exhibit F. June 2, 1998, Exhibit FF. September 18,
3 1998, when he signed the certification. He doesn't
4 provide us with anything. Nothing. Neither does Dr.
5 Fowler's office. Neither is there anything on the
6 record at all about that.

7 I have to smile because in their Answer, page 6,
8 paragraph 34, Defendant admits that decedent had a duty
9 to be truthful on any and all applications,
10 certifications, and affirmations to Medicare and/or
11 Plaintiff. How much clearer does it get? How much
12 clearer does it get regardless of the oratory, that we
13 have listened to today from Mr. Josey.

14 **THE COURT:** All right. Counsel, I think I've got
15 an understanding of both sides of the summary judgment
16 issue.

17 Let's move forward to 59(e), and let me hear from
18 you briefly why you believe we should reconsider the
19 decision to disqualify.

20 **MR. MEGNA:** Your Honor, we have signed Affidavits
21 with the Court indicating that Dr. Matthews, Dr.
22 McInnis, Dr. Pellman {sic.} --- I would segregate it
23 from Dr. Thompson and the providers. Yes, I had at some
24 point ultimate control, if I really wanted something
25 done, I guess. I was the CEO of the organization. But,

1 we purposely, our entire time we have been together, we
2 have always, always dealt with providers differently
3 than the administrative staff. I have never had any
4 contact with it. I have had nothing to do with it. And
5 there is not a bit of evidence before this court, zero
6 that I had anything that I needed to testify about.
7 That I have anything --- I had no meetings with Dr.
8 Thompson about this. I didn't know about it. They
9 haven't produced anything. Zero. Nothing. Nothing.
10 As a matter of fact, where is that paper that you got
11 today, that you showed me today. We just want to show
12 you something. We are going to admit it as an exhibit,
13 because it came from --- There was a big discussion
14 about what was on the bottom of Exhibit HH, this is an
15 Order that was filed January 18, in this same case. And
16 it has very similar writing on the bottom. It didn't
17 come from our office. And, unless you have --- take
18 judicial notice, as a matter of fact, Mark seems to
19 think it came from your office, if you look at the
20 bottom of it. The defendant took some writing on the
21 bottom of Exhibit HH, and said that somehow another they
22 needed to depose me to find out what happened to it.

23 **THE COURT:** All right. That will be Defendant 2.

24 **MR. MEGNA:** The point of this document --

25 **THE COURT:** Let's wait just one moment while we

1 mark it.

2 WHEREUPON, DEFENDANT'S
3 EXHIBIT NUMBER 2, IS
4 MARKED AND ADMITTED INTO
5 THE RECORD.

6 THE COURT: All right. Thank you.

7 MR. MEGNA: The point of this document, and then
8 we submit it is that the writing that appears on this
9 document is very similar to the document that they
10 previously said was Document HH. You know, there is
11 some notation made at the bottom of it. You know, I got
12 a date and a time or something like that. It had
13 nothing to do with us. And that was with the Court ---
14 that they were focusing on with the Court to base its
15 decision. There is not one bit of evidence --- evidence
16 before this court; none, that I have anything to do or
17 had any conversation with Dr. Thompson about this.
18 None. You know, on pure speculation, they decided that
19 somehow I needed to be deposed. All the Affidavits ---
20 the only evidence before the Court indicates just the
21 contrary. And, I simply don't understand how on that
22 kind of speculation that something as important as a
23 chosen counsel --- a chosen choice of counsel that the
24 Court could just decide to disqualify me, because
25 somebody says I might have something. And that is my

1 concern. It just doesn't make sense.

2 **THE COURT:** All right.

3 **MR. MEGNA:** And my other concern, Your Honor, and
4 just the final analysis is that we put out \$226,000. We
5 admit our liability to Medicare.

6 And I close with saying this is not about our
7 liability to Medicare. What about his liability to tell
8 the truth to Medicare, and to us. And we do have a lot
9 of causes of action, because we want to give this court
10 a lot of alternatives. Breach of contract, breach of
11 fiduciary duty, indemnification, and the list goes on.
12 We think that even under these limited circumstances, we
13 are entitled to summary judgment. But even if the Court
14 decides that under these circumstances it can't we need
15 to take the depositions of these folks to find out what
16 is going on.

17 **THE COURT:** All right. Thank you.

18 **MR. MEGNA:** Thank you, Your Honor.

19 **THE COURT:** And again on 59(e), is there a reply?

20 **MR. JOSEY:** First of all, Your Honor, on the
21 59(e), I guess we would argue in the alternative that
22 there should be a dismissal for failure of timely filed
23 after service. And then we would argue in the
24 alternative that the Motion should be denied on the
25 merits.

1 As we pointed out in our Memorandum, while they
2 timely served their 59(e) Motion, they apparently took
3 it down to the Clerk's Office, without the necessary
4 cover sheet, without the necessary \$25.00 filing fee.
5 The Clerk's Office accommodated them by clocking it in,
6 but told them, as I understand, that it would not be
7 under --

8 **MR. MEGNA:** -- Your Honor, I am going to object
9 if he is going to testify. I mean, that is not
10 appropriate.

11 **THE COURT:** All right, the objection is noted for
12 the record. Let me just hear what it is that he is
13 going to say.

14 **MR. JAMES:** But, in any event, the Motion's cover
15 sheet did not accompany the filing. The \$25.00 did not
16 accompany the filing. Rule 5(d) says that the filing
17 must be made within five days of service. They did not,
18 other than having the document clocked in, they did not
19 perfect the filing. They attempted to perfect the
20 filing on May 26th. At that time they gave to the
21 Clerk's Office the \$25.00. They gave to it a cover
22 sheet that is unsigned by anybody. The cover sheet said
23 that oral arguments were not needed. The cover sheet
24 did not give the information as to who the attorneys
25 were. No information as to the attorneys. It was

1 slightly more than a blank cover sheet. But that was
2 it. Rule 5(d) says that where there is not proper
3 filing, the Court can either accept the filing if it is
4 made late, or the Court can dismiss. So, the question
5 here is, should there be any remedy or penalty for
6 failure to do this thing correct. As the Court is
7 aware, this is not the first time that this plaintiff
8 has stumped its toe on procedural grounds.

9 **MR. MEGNA:** I object again, Your Honor. I have
10 no idea what he is talking about.

11 **MR. JAMES:** I am talking about the Probate Court,
12 failure to file the --

13 **MR. MEGNA:** -- That is on appeal, Your Honor.
14 That order has been stayed, and I do oppose it, and I
15 think it is absolutely out of order.

16 **THE COURT:** All right. Well, Mr. Megna, I am
17 again going to note your objection for the record. And
18 I am going to allow Mr. James to make his argument.
19 Go ahead, sir.

20 **MR. JAMES:** In summary, we would ask the Court to
21 just dismiss the Rule 59(e) Motion, because of the
22 imperfections in the filing.

23 **THE COURT:** All right.

24 **MR. JAMES:** But, in the alternative, we would ask
25 the Court to deny --- We think the Court correctly

1 stated and applied the law to the facts of this case, in
2 its order of April 15th.

3 And, then the Court said that Mr. Megna was a
4 necessary witness, and he should be disqualified. We
5 would point out that Mr. Megna's law partner, Ben
6 Matthews, who is here again today, signed the Summons
7 and Complaint in this case last May. He further signed
8 the plaintiff's first interrogatories; first Request for
9 Production for Documents. He also signed the
10 Plaintiff's Answers to the Defendant's first
11 Interrogatories, and the Answer the Defendant's first
12 Request for Production of Documents. He also signed
13 Amended Answers to the Interrogatories. He signed the
14 Plaintiff's Response to the Defendant's Request for
15 Admissions. That was no November 9, 2010. His
16 signature further appears on the Motion's cover sheet
17 for the Summary Judgment on December 9, 2010. So, Mr.
18 Matthews has been heavily involved in this case. Since
19 December 9, 2010, Mr. Matthews, for reasons we do not
20 know, has seemingly disappeared from the case. But, he
21 has not given any Notice of Withdrawal, so we assume
22 that he is still one of the counsel of record.

23 Mr. Megna's overt role in terms of signing
24 pleadings and other discovery documents did not become
25 apparent until he signed the Motion for Summary

1 Judgement, or had the Motion signed for him shortly
2 before Christmas 2010, December 9th. And we moved
3 promptly after the first of the year to disqualify him
4 for the grounds stated in our Motion to Disqualify.

5 We think the Court correctly ruled that no
6 prejudice should occur to the plaintiff by disqualifying
7 Mr. Megna, since his law partner, Mr. Matthews, was
8 available and was already heavily involved in the case.

9 We think further that the Court correctly ruled
10 that Mr. Megna was a necessary witness, despite his
11 protest to the contraire. In his Rule 59(e) Motion, the
12 plaintiff set forth four basic grounds for this Court to
13 reconsider its April 15 Order. The first ground was
14 that the Court's reliance on the Exhibit HH, which was
15 also the omitted exhibit from the Complaint, that the
16 reliance on that exhibit to disqualify Mr. Megna was in
17 error. The apparent basis for this argument is that
18 plaintiff now contends that Exhibit HH, which it
19 submitted to this court is not the authentic document,
20 and that the authentic HH does not contain the partial
21 handwritten notation in the lower right-hand corner.
22 Mr. Mark Matthews, in his Affidavit in support of
23 plaintiff's Rule 59(e) Motion, attached a "Clean Exhibit
24 HH" and said that plaintiff had no document in its files
25 such as the Exhibit HH, which it filed with the notation

1 in the lower right-hand corner. Mr. Matthews further
2 professed bewilderment as to how subject document came
3 into the plaintiff's possession. We responded to that
4 with a series of correspondences in late May of 2010,
5 and included in that correspondence is an email from Mr.
6 Megna to me where he sent me the --- what is now Exhibit
7 HH. It was meant to be attached to the complaint, but
8 it was omitted from the complaint. He now says, in his
9 response to our response to the 59(e) Motion, Mr. Megna
10 says that Exhibit HH and the writing on the bottom of it
11 and any similar matters are at best a "red hearing." I
12 guess he says that we are now trying to mislead the
13 Court with his exhibit. It is his exhibit to the
14 complaint, his Exhibit HH. That is preposterous. He
15 further says that the Defendants arguments concerning
16 this exhibit, is nothing but a rhetorical and literary
17 tactics to defer attention from the real issues. What
18 the defendant showed in its response to the Rule 59(e)
19 Motion was that Exhibit HH was the handwritten notation,
20 was furnished by Mr. Megna himself, shortly after the
21 commencement of litigation, and before the allegedly
22 altered document to come into plaintiffs' possession
23 through a third party. Frankly, it looks like to me
24 they have disowned Mr. Mark Matthew's Affidavit and
25 perhaps thrown him under the bus.

1 But it is just not the Court's reliance on Exhibit
2 HH that makes --- It is not just Exhibit HH that makes
3 Mr. Megna a necessary witness. In the complaint,
4 Exhibit HH was said to be the smoking gun given by Dr.
5 Thompson who Mr. Megna that he made certain admissions
6 at about that time. Well, we need to ask Mr. Megna a
7 lot of questions about the unsigned, undated document.
8 When he got it, what its context is, whatever
9 handwritten notation, etcetera. But there are other
10 matters that Mr. Megna as the CEO would be very
11 important as a witness. Matters as to credentialing.
12 Matters as to due diligence. Matters as to records
13 keeping. Matters as to file destruction. Matters as to
14 communication in the Medicare litigation. And we have
15 asked for various documents that might have been in Dr.
16 Thompson's file, such as employment applications. We
17 are told that in the normal course of things they
18 destroy files after so many years, and most of Dr.
19 Thompson's files have been destroyed. Well, we need to
20 know from the CEO of that organization what is going on.

21 The plaintiff's response further said that the
22 59(e) Motion should be granted because this court failed
23 to recuse itself from hearing matters concerning the
24 plaintiff, due to litigation pending in Florence County,
25 where this court often sits by designation. And I don't

1 know if that is still the position, or if he has dropped
2 that position.

3 **MR. MEGNA:** No, sir. Our position is that it is
4 the Court's decision. I think it was our opportunity,
5 and our duty to raise the issue. We don't know the rest
6 of it. We know that we have a responsibility, and that
7 I strongly object to the use of the word preposterous.
8 If there is anything preposterous, it is your
9 strategies.

10 **THE COURT:** All right. Gentlemen, let's do this.
11 Mr. James, rather than take further argument, I have had
12 the opportunity to review your Memoranda that you filed
13 on these points. And, I have heard sufficient argument
14 really from both sides. We are on a Motion to
15 Reconsider, and thus I am going to end argument at this
16 time, and take that matter under advisement, and rule at
17 a later time. And accept your Memoranda as your final
18 argument.

19 **MR. JAMES:** I am basically rehashing the
20 Memoranda, Your Honor.

21 **THE COURT:** Yes, sir. I follow that. So, what
22 we are going to do is, we are going to end the record
23 for the day. We have reached far beyond our court time
24 generally. And take both these matters, really all
25 three, Summary Judgment times two, plus this

1 Reconsideration Motion under advisement.

2 We will be in touch with you in the near future
3 with a decision.

4 **MR. MEGNA:** Your Honor, just for the record. We
5 want to make sure that the record reflects that there
6 were documents collected prior to any of this, and that
7 his arguments are preposterous.

8 **THE COURT:** Well, we will leave the issues where
9 we are, and close the record for the day.

10 This court is now in recess.

11 (Whereupon, this hearing was concluded at
12 6:03 p.m..) On Tuesday, July 19, 2011.)

13 -- END OF RECORD --

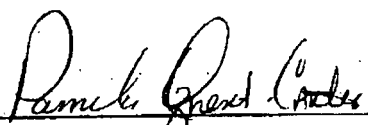
CERTIFICATE OF REPORTER

58

I, the undersigned, Pamela Ozment-Cartee, official Court Reporter for the Fourth Judicial Circuit of South Carolina, do hereby certify, that the foregoing is a true, accurate and complete Transcript of Record in the hearing of the above captioned case, relative to appeal, in The Court of Common Pleas in Darlington County, South Carolina, on the 19th day of July 2011.

I do further certify that am neither, of kin, counsel, nor interest of any party hereto.

August 15, 2011



Pamela Ozment-Cartee
Circuit Court Reporter



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 11 1996

Eugene A. Laurant, PhD
Executive Director
State Health & Human
Services Finance Commission
Post Office Box 8206
Columbia, South Carolina 29202-8206

Dear Dr. Laurant:

Re: Hugh S. Thompson Medical Doctor
115 N. Ervin Street
Darlington, South Carolina 29532

SANCTION AUTHORITY 1128(b)(4)	DOB 02/10/40
PERIOD OF EXCLUSION Indefinite	SSN 251-62-3993
OI File No. 4-95-40434-9	PROVIDER NUMBER Unknown
UPIN D99321	

The subject identified above is being excluded from participation in the title XVIII (Medicare) and any State health care program for the period shown above. This action is effective 20 days from the date shown on this letter.

Pursuant to section 1128 of the Social Security Act (Act), the subject must also be excluded from participation in the title XX program for the same period of time. If you have not already done so, please take the necessary action in accordance with section 2005(a)(9) of the Act to exclude the subject from participation in the title XX program.

At the end of the exclusion period, the subject may be eligible for reinstatement. We will consult with you regarding any such action and will notify you if and when reinstatement occurs.

Sincerely yours,

Wm Libercci

William M. Libercci
Director
Health Care Administrative Sanctions



South Carolina Board of Medical Examiners

Koger Office Park, Kingman Building
110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211-1289

(803) 896-4500
FAX: (803) 896-4515

April 14, 1998

Hugh S. Thompson, M.D.
111 North Ervin Street
Darlington, SC 29532

Dear Dr. Thompson:

This is to confirm the following:

1. Receipt of payment of \$5,000 fine as mandated by this Board's Final Order dated May 31, 1994;
2. Documentation of completion of "Prescribing Controlled Drugs" sponsored by Vanderbilt University School of Medicine, as well as your critique of same; and
3. Successful passage of the Special Purpose Examination.

Pursuant to receipt of the above, the Board has reinstated your South Carolina medical license, number 7087, effective immediately. However, this license is reinstated with the condition that any practice setting must be pre-approved in writing by the Board and you will be allowed to write prescriptions for in-house use only.

The Board wishes you well in your practice of medicine in South Carolina.

Sincerely,



Aaron J. Kosloski
Administrator

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION

David M. Bentley
Governor

Leslie F. Gossard
Director

DATE: 04/03/03 12:13:31

PLEASE CHECK ALL THAT APPLY (for administrative purposes only):

PLEASE CHECK ALL THAT APPLY (for administrative purposes only):

PLEASE CHECK APPLICABLE BOX

Only if this entire section does not apply to the applicant.

First Name: Thompson, Last Name: Thompson, J.S. MD, MS

Address: 1989, City: 1989, State: GA, Country of Birth: USA

Only if this entire section does not apply to the applicant.

Parental Medical History: RECEIVED

Only if this entire section does not apply to the applicant.

CERTIFICATION

COPY

D. All Applicants

Under what name does applicant conduct business at this location?

(Doing Business As Name)

Hugh S. Thompson, M.D.

Mailing Address Line 1

P.O. Box 875

Mailing Address Line 2

City

Marion

County

Marion

State

SC

2553/1/18/5

Telephone Number

(843) 423-4049

Fax Number

(843) 423-5424

E-mail Address

hst@hst.com

Business License Number

HA 570693462

SC 121621843

Does applicant now have or has applicant ever had a Medical or Medical Assistant license in any other state?

☐ Yes ☒ No

If Yes, supply all current and prior information regarding same.

Current Career Name (if applicable)

Current Intermediate Name (if applicable)

Current Medical Assistant Name (if applicable)

Prior Career Name (if applicable)

Prior Intermediate Name (if applicable)

Prior Medical Assistant Name (if applicable)

Current CJA Number (if applicable)

Prior CJA Number (if applicable)

Mailing Address Line 1

P.O. Box 875

Mailing Address Line 2

City

Marion

State

SC

2553/1/18/5

Attach a copy of each required Federal, State, and/or local business license, registration, or certification. Notarized or "certified true" copies are optional but may be used in lieu of the original.

Has applicant ever had any Federal, State, and/or local business and/or professional business license, registration, or certification revoked or suspended? ☐ Yes ☒ No

Check here ☐ only if this entire section does not apply to the applicant.

Attach a copy of each degree or certificate. Notarized or "certified true" copies are optional but may be used in lieu of the original.

Source Name

Medical University of South Carolina

City

Charleston 29401

State

SC

2553/1/18/5

Check here ☒ only if this entire section does not apply to the applicant.

If applicant is Board Certified in his/her primary specialty, complete the following information.

Certification Board Name

NCB 00501 1.8.17.19.50

Certification Number

1.8.17.19.50

Expiration Date

1.8.17.19.50

10/15/97

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04/03/03 12:13:31 PAGE 003 OF 058

OMB Approval No. 0950-0045

1. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

2. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

3. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

4. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

5. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

6. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

7. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

8. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

9. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

10. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

11. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

12. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

13. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

14. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

15. Has the applicant ever been arrested, convicted, or excluded from any other Federal benefit or program? ☐ Yes ☒ No. If YES, supply the following information:

1. Name of Federal Agency: U.S. Marshals Service 2. Date of Arrest/Conviction/Exclusion: 04-24-1992

COPY

Check here ☒ only if this entire section does not apply to the applicant.

If applicant has previously billed the Medicare or Medicaid programs for services, please provide the following information for each prior practice, copy and complete Section 8.

Type of Practice: ☐ Sole ☐ Franchise ☐ Active ☐ Inactive

Legal Business Name: _____

Medicare Identification Number(s): _____ Medicaid Number(s): _____ Taxpayer Number: _____

Business Street Address Line 1: _____

Business Street Address Line 2: _____

City: _____ State: _____ Zip: _____

Was applicant a participating or non-participating provider/supplier in this prior practice? ☐ Participating ☐ Non-participating

Does the applicant have any outstanding overpayments with Medicare? ☐ Yes ☒ No

Check here ☐ If delegating this Managing/Directing employee, please provide the following information.

Effective date of delegation: _____

How many managing/directing employees does applicant employ at this location? _____ (maximum of 25)

For each managing/directing employee, copy this page and complete Section 9.

A. Identifying Information

Name: First DON Middle H Last WILLIAMS Social Security Number 457 484 072 Employer Identification Number (if applicable) 59-1693462 Medicare Identification Number (if applicable) 100-1-58-1939

Date of Birth 06/25/1952 Sex Male Country of Birth USA

B. Does this Managing/Directing employee now have or ever had a Medicare or Medicaid number? ☒ Yes ☐ No If YES, supply all current and prior Medicare/Medicaid numbers required below.

Current Carrier Name (if applicable) PG BA Current Fiscal Intermediary Name (if applicable) Medicare-SI Current Medicare Number (if applicable) 100-1-58-1939

Prior Carrier Name (if applicable) _____ Prior Fiscal Intermediary Name (if applicable) _____ Prior Medicare Number (if applicable) _____

C. Has this Managing/Directing employee ever managed/directed or had control over a Medicare or Medicaid provider or supplier? ☐ Yes ☒ No If YES, how many? _____ Complete below for each organization.

Legal Business Name: _____ Medicare Identification Number: _____ Employer Identification Number: _____

Current Carrier Name (if applicable): _____ Current Fiscal Intermediary Name (if applicable): _____ Current Medicare Number (if applicable): _____

Prior Carrier Name (if applicable): _____ Prior Fiscal Intermediary Name (if applicable): _____ Prior Medicare Number (if applicable): _____

D. Has this Managing/Directing employee ever been employed by a Medicare or Medicaid provider or supplier, or been employed by any other Federal agency or program? ☐ Yes ☒ No If YES, supply the following information.

Date(s) of Service, Department, etc. 06/1990 Employer Identification Number 59-1693462

E. Have civil/punitive penalties ever been levied against this Managing/Directing employee by the Medicare/Medicaid program or any Federal agency or program? ☐ Yes ☒ No If YES, has penalty been paid? ☐ Yes ☒ No

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Check here ☒ only if this entire section does not apply to the applicant.
 If this entity is a subsidiary company or joint venture, check appropriate box below:
☐ Subsidiary Company ☐ Joint Venture
 Is this a free-standing unit? ☐ Yes ☐ No
 Attach a copy of parent company or other owner's IRS Form 990 (if applicable) showing business activity.
 IF Subsidiary Company or Joint Venture, complete the information below about the PARENT company (ONLY write Legal business Name)

Doing Business As Name		Business Identification Number	
Employer Identification Number		Mastercard/Discover Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Address (Not for Line 2)	
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Address (Not for Line 2)	
Business Street Address Line 1			
Business Street Address Line 2			
City	County	State	Zip Code
Telephone Number	Fax Number	E-mail Address	

This section to be completed by Part A Institutional Providers only.
 Check here ☒ only if this entire section does not apply to the applicant.
 Does the applicant need to register a chain station? (see Act below) ☐ Yes ☐ No
 IF YES, check the appropriate select:
☐ Applicant is chain station
☐ Applicant is a different chain station
☐ Applicant is part of a chain
☐ Applicant in same chain under new chain name

Complete the following information about the chain Home Office:

Name of Home Office				Effective Date of Chain	
Name of Home Office	First	Middle	Last	Address	Telephone Number
Administrative CEO:				Title of Administrative CEO	
Home Office Business Street Address Line 1					
Business Street Address Line 2					
City	County	State	Zip Code	Fax Code	
Telephone Number	Fax Number	E-mail Address			
Chain Number	Name of Home Office Intermediary Carrier				
Applicant's Address to Chain:		☐ Joint Venture/Partnership		☐ Licensed/Registered	
		☐ Operated/Related		☐ Privately Owned	
Fiscal Year End Date of this Chain (MM/DD)		Do all the providers/stations of the chain use the same Part A fiscal year end? ☐ Yes ☐ No			

104-106 (8/97)

7 of 18
COPY

Check here ☐ If deleting (no longer using) this contractor.

Check here ☒ only if this entire section does not apply to the applicant.

Have any business organization contractors does the applicant use?

For each business organization contractor, copy this page and complete Section 14.

A. Does the applicant contract for any medical or diagnostic services with a business organization for which the total or value is \$10,000 or more in a 12-month period? ☐ Yes ☐ No

IF YES, complete the information below for each business organization contractor with whom the applicant has a contract.

Legal Business Name

Doing Business As Name

Business Street Address Line 1

Business Street Address Line 2

City

State

ZIP Code + 4

Telephone Number

Fax Number

Employer Identification Number

B. Does this contractor now have, or has this contractor ever had a Medicaid or Medicare provider number in this or any other state? ☐ Yes ☐ No

IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)

Current Provider Information (if applicable)

Prior Carrier Name (if applicable)

Prior Provider Information (if applicable)

C. Has this contractor ever been sanctioned from the Medicaid/Medicare program, or been suspended or excluded from any other Federal agency or program? ☐ Yes ☐ No

Date(s) of Sanction, Exclusion, etc.

D. Have civil monetary penalties ever been levied against this contractor by the Medicaid/Medicare program or any Federal agency or program? ☐ Yes ☐ No

IF YES, has penalty been paid? ☐ Yes ☐ No

Check here ☐ If deleting (no longer using or changing) this contractor.

Check here ☒ only if this entire section does not apply to the applicant.

Complete this section if applicant will be using a billing agency or management services organization.

Applicant MUST submit a copy of the applicant's current signed billing management contract with this application.

Name of Billing Agency/Management Service Organization

Agency/Organization

First

Middle

Last

Contact Person

Business Street Address Line 1

Business Street Address Line 2

City

State

ZIP Code + 4

Telephone Number

Fax Number

Employer Identification Number

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PAGE 08 OF 058
04/03/03 12:13:31

001039 ELIZABETH CYRESS

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OMB Approval No. 0905-0055

Check box if you are a provider or subcontractor who is submitting this application.

Check box if you are a provider or subcontractor who is submitting this application electronically.

Name of the provider or subcontractor: HERNANDEZAddress: 300 RIVER STCity: NEW YORK State: NY Zip: 10014Phone Number: 212 345 4321Fax Number: 212 345 4321E-mail Address: FWLERPHC@AOL.COM

Check box if you are a provider or subcontractor who is submitting this application.

Check box if you are a provider or subcontractor who is submitting this application electronically.

Name of the provider or subcontractor: HERNANDEZAddress: 300 RIVER STCity: NEW YORK State: NY Zip: 10014Phone Number: 212 345 4321Fax Number: 212 345 4321E-mail Address: FWLERPHC@AOL.COM

Check box if you are a provider or subcontractor who is submitting this application.

Check box if you are a provider or subcontractor who is submitting this application electronically.

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Check box if you are a provider or subcontractor who is submitting this application electronically.

Name of the provider or subcontractor: HERNANDEZAddress: 300 RIVER STCity: NEW YORK State: NY Zip: 10014Phone Number: 212 345 4321Fax Number: 212 345 4321E-mail Address: FWLERPHC@AOL.COM

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Penalties for Falsifying Information on the Medicare Health Care Provider Billing System

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact; makes any false, fictitious or fraudulent statements or representations; or makes any false writing or document knowing the same to contain false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. § 1001. Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender, if the greater than amount specifically authorized by the underlying statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under a program under a Federal health care program."

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. section 3729, imposes civil liability, in part, on any person who:
- a.) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
 - b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus 3 times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency, or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency, ... a claim: ... that the Secretary determines is for a medical or other item or service that the person knows or should know:
- a.) was not provided as claimed; and/or
 - b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.

HCFA 98-007

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FORNARD: D001039 ELIZABETH CYRESS
6662251623993

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OMB Approval No. 0938-0001

The undersigned hereby certifies to the following:

I have read the contents of this application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare Contractor of this fact immediately.

I authorize the Medicare Contractor to verify the information contained herein. I agree to notify the Medicare Contractor of any change in the information within 30 days of the date of the change. I understand that a change in the incorporation or any other information may require a new application.

I understand that the Medicare Contractor may require a new application if my provider/supplier type.

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I understand that the Medicare Contractor may require a new application if my provider/supplier type.

COPY

98153961224

CMS Approval No. 0008-0008

THIS FORM IS TO BE COMPLETED BY THE GROUP/PARTNERSHIP OR GROUP MEMBER/PARTNER WHEN ANY OF THE SITUATIONS LISTED BELOW ARE PRESENT:

1. INDIVIDUAL PRACTITIONER IS CURRENTLY ENROLLED IN THE MEDICARE PROGRAM AND JOINING A GROUP/PARTNERSHIP THAT IS CURRENTLY IN THE MEDICARE PROGRAM AND WHERE THE INDIVIDUAL PRACTITIONER WILL REASSIGN BENEFITS TO THE GROUP/PARTNERSHIP.
2. A NEWLY ENROLLING GROUP/PARTNERSHIP TO LIST ALL GROUP MEMBERS/PARTNERS RENDERING SERVICES WITHIN THE GROUP/PARTNERSHIP SETTING; NOTE: ENROLLING GROUP/PARTNERSHIP AND ALL GROUP MEMBERS OR PARTNERS NOT CURRENTLY ENROLLED IN THE MEDICARE PROGRAM MUST ALSO COMPLETE THE HCFA FORM 855 (GENERAL APPLICATION).
3. A MEDICARE GROUP/PARTNERSHIP WISHING TO ADD OR DELETE A MEDICARE INDIVIDUAL PRACTITIONER TO OR FROM THE GROUP/PARTNERSHIP; NOTE: WHEN ADDING AN INDIVIDUAL PRACTITIONER WHO IS NOT ENROLLED IN THE MEDICARE PROGRAM, THE INDIVIDUAL PRACTITIONER MUST COMPLE THE HCFA FORM 855 (GENERAL APPLICATION) AND ENROLL IN THE MEDICARE PROGRAM PRIOR TO BEC

Check here

☐

If only reporting exchange of member/partner status.

On April 11

TNER.

Notepad

Put #1 from letter - Provisional license from SC Board Med. Ed.

Legal Business Name

Fowler Assoc., P.A. of Marion

Doing Business As Name

Group Employer Identification Number

570693462

Group Medicare Identification Number

C613591989

Adding or Listing

☒

Member

Newborn

05/18/1998

Delete Member

☐

Date Member Left Group (if applicable)

Newborn

NAME

First

HUGH

Last

SMITH

Last

THOMPSON

A. B. M.D. or

MD

Social Security Number

251 62 3993

Medicare Identification Number

Applied

Date of Birth

08/10/1944

What income reporting form does this member receive from the member's employer or the Internal Revenue Service at the end of the calendar year?

☒ W-2☐ 1099-MISC☐ 1099-DIV

If more space is needed, copy page and attach to application.

Legal Business Name at this location

Fowler Assoc., P.A. of MARION (1989)

Doing Business As Name at this location

Business Street Address Line 1

210 E. DUZIER STREET

Business Street Address Line 2

City

MARION

County

MARION

State

SC

ZIP Code + 4

22571-0875

Are all patient records stored at this practice location?

☒ Yes☐ No

If NO, supply storage location below.

Name of Storage Facility/Location

HCFA 855 (04/97)

COPY

Street Address Line 1

Street Address Line 2

City	County	State	ZIP Code - 4
Telephone Number ()	Fax Number ()	E-mail Address	

Medicare law prohibits payment for services to entities other than the practitioner who provided the services unless the practitioner specifically authorizes another entity (employer, facility, health care delivery system, or agent) to bill for his or her services, per Federal Regulation 42 CFR 424.73 and 424.89. The Reassignment of Benefits Statement below authorizes an entity for which you have an agreement to bill for your services on your behalf.

This contract must be in compliance with HCFA regulations, as outlined in number 18 of the application instructions. A Reassignment of Benefits Statement must be signed by all providers, suppliers, and individuals who follow an employer, facility, health care delivery system, or agent to receive payment for the provider's services.

I acknowledge that, under the terms of my employment or contract

(Legal Business Name of Entity)

is entitled to claim or receive any fees or charges for my services.

Applicant Name (Printed)	First	Middle	Last	State
	Hugh	Smith	Thompson	MD
Applicant Signature	Date			
	05/29/1992			

Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application

- 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. § 3471. Section 3471(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
- Section 1120(b)(1) of the Social Security Act authorizes criminal penalties against an individual who knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program. The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.
- The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:
 - a.) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
 - b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.
 The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus 3 times the amount of damages sustained by the Government.
- Section 1124(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency, a claim, that the Secretary determines is for a medical or other item or service that the person knows or should know:
 - a.) was not entitled to be claimed; and/or
 - b.) the claim is false or fraudulent.
 This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.
- The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.

HCFA-893 (4/97)

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04/03/03 12:13:31 PAGE 013 OF 058

ELIZABETH CYPRESS

001039

COPY

OMB Approved No. 0725-0045

Please attach this application and Medicare number of a person who can answer questions about the information limited in this application.

First Name	DOB	Last Name	Address	City, State, Zip	Signature Number
ROGER		HERNANDEZ			184514254044

I, the undersigned, certify to the following:

1. I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare Contractor of this fact, immediately.
2. I authorize the Medicare Contractor to verify the information contained herein. I agree to notify the Medicare Contractor of any change in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or any status as an individual or group biller may require a new application.
3. I am terminating and agree to abide by the Medicare laws and regulations that apply to my provider/supplier type. (The Medicare laws and regulations are available through the Medicare Contractor.)
4. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicare/Medicaid program or debarment, suspension, or exclusion under any other Federal agency or program, or otherwise is prohibited from providing services to Medicare beneficiaries.
5. I agree that any existing or future overpayment to me by the Medicare program may be recouped by Medicare through withholding future payments.
6. I understand that only the Medicare billing number for the provider/supplier who performed the service or to whom benefits have been rendered under current Medicare regulations may be used when billing Medicare for services.
7. I understand that any conviction, misrepresentation or falsification of any information contained in this application or contained in my organization supplying information to Medicare to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of Medicare billing number(s), fines, penalties, damages and/or imprisonment under Federal law.
8. I further certify that I, as the individual practitioner who is applying for the billing number, or in the case of a business organization, I, as an officer, chief executive officer, or general partner of the business organization that is applying for the Medicare billing number.

Signature of Applicant	First Name	Last Name	Address	City, State, Zip
<i>[Signature]</i>	ROGER	HERNANDEZ	5	THOMPSON MAD
Signature of Representative	First Name	Last Name	Address	City, State, Zip
<i>[Signature]</i>	ROGER	HERNANDEZ	5	THOMPSON MAD
Date	06/19/1998			

or for group/supplier/supplier billing individual practitioners or reporting a change of member/partner status:

Group/Partnership Signature	First Name	Last Name	Address	City, State, Zip
Administrative Name (if not same as above)	DAN	HA	FRANKE	THOMPSON MAD
Authorized Signature	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Date	05/24/1998			

FORM 1000-0002

COPY



Hugh S. Thompson, M.D.
P.O. Box 875
Marion, SC 29571-0875

We have received your application for enrollment as a provider/supplier in the Medicare program. Some requested information is missing. Please see the accompanying document that identifies information that must be submitted. All submissions must include a signed certification statement (section 19 page 11 of 16).

Send the requested information to:

If we may be of further assistance, please call the Medicare B Customer Service at (803) 788-5568. A customer service representative will assist you.



Medicare

Palmetto Government Benefits Administrators

Part B Carrier

Post Office Box 100190

Columbia, South Carolina 29202-3190

ADDITIONAL INFORMATION REQUEST

Return the enclosed HCFA 855 enrollment form, completing the following sections and/or attaching the requested documentation:

Please complete section 4 - Tax Id# and Social Security number.

Please complete section 5.

Please complete section 6 - enclose a copy of the reinstatement letter from the Department of Health and Human Resources.

Please complete section 7 - date began at location.

Please complete section 9a - county of birth.

Please complete section 9d - check the box. A copy of the reinstatement letter from the Department of health and Human Resources.

Please complete section 10 - Effective date of ownership, county of birth and a copy of your reinstatement letter.

Please complete section 11, 12, 13, 14, 16.

Please complete section 19 - re-sign and date.

On the HCFA 855-G:

Please complete section 1 - date member joined the group.

Please complete section 6 - group member partner name section must be completed.

Send the requested information to:

Medicare Provider Certification AK-125
Post Office Box 100190
Columbia, South Carolina 29202-3190

If we may be of further assistance, please call the Medicare B Customer Service at (803) 788-5568. A customer service representative will assist you.

Sincerely,

Dawn Johnson
Medicare B Provider Certification

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION
Individual Reassignment of Benefits Application

98313900111

98324

THIS APPLICATION IS TO BE COMPLETED FOR ANY INDIVIDUAL WHO WILL REASSIGN HIS OR HER BENEFITS TO AN ELIGIBLE ENTITY. 98324900647

Check box indicating the reason this application is being completed.
 (Note: definitions of the following terms are found in the instructions.)

- ☐ Initial Enrollment
☐ Deleting a Reassignment
☐ Changes of Ownership (CHOW)

- ☒ Adding a Reassignment
☐ Changing Status of an Individual

RECEIVED

20 1996

RECEIVED

11/3/96

1. Entity Identification		MEDICARE PROVIDER CERTIFICATION	
Legal Business Name Pee Dee Health Care, Inc.		Entity Medicare Identification Number 1724	
"Doing Business As" Name Same		Entity Employer Identification Number 570638347	

2. Individual Identification		MEDICARE PROVIDER CERTIFICATION	
Adding or Listing Individual ☒		Date Individual Reassigned Benefits (required) (MM/DD/YYYY) 10/26/1998	
Deleting Individual ☐		Date Individual Terminated Reassignment (if applicable) (MM/DD/YYYY)	
Name: First Hugh	Middle S	Last Thompson	Jr., Sr., etc. MO
Social Security Number 251-62-3993		Medicare Identification Number D99321	Date of Birth (MM/DD/YYYY) 02/10/40
Individual Primary Specialty Anesthesiology		Individual Secondary Specialty (optional) NA	
What income reporting form does this individual receive from the entity or the Internal Revenue Service at the end of the calendar year? ☒ W-2 ☐ 1099 ☐ 1099-K1 ☐ Other			

3. Practice Locations			
At how many locations does this individual render services for the entity identified above? <u>1</u>			
List all locations where this individual will render services for this entity.			
If additional space is needed, copy page, complete this section and attach to application.			
Legal Business Name For This Location Pee Dee Health Care, Inc.		NOV 9 1998	
"Doing Business As" Name For This Location Same		M.D., D.O., or	
Business Street Address Line 1 201 Cashua Street		M.D., D.O., or	
Business Street Address Line 2		M.D., D.O., or	
CITY Darlington	COUNTY Darlington	STATE SC	ZIP Code + 4 29532

Palmetto Government Benefit Administrators
 Med B - Document Control - Camden, SC

RECEIVED

SENT

0822507



Medicare
Palmetto Government Benefits Administrators
Part B Carrier
Post Office Box 100190
Columbia, South Carolina 29202-3190

ADDITIONAL INFORMATION REQUEST

Return the enclosed HCFA 855 enrollment form, completing the following sections and/or attaching the requested documentation:

The HCFA 855 is complete, however, we need some additional information.

Please send your letter of reinstatement from the Office of Inspector General.

Send the requested information to:

Medicare Provider Certification AK-125
Post Office Box 100190
Columbia, South Carolina 29202-3190

If we may be of further assistance, please call the Medicare B Customer Service at (803) 785-5568. A customer service representative will assist you.

Sincerely,

Gina Kelly
Medicare B Provider Certification



MEDICARE

Part A Intermediary
Part B Carrier
ONE Regional Center

DATE: December 8, 1998

Hugh S. Thompson, M.D.
Pee Dee Health Care, Inc.
281 Castula St.
Burlington, SC 29312

Dear Dr. Thompson:

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and/or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and/or practitioner(s). The number(s) listed below have the participation status of the group practice. If a number has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Provider Name	Provider Number	Effective Date	Expiration Date
Hugh Thompson	D995211724	October 26, 1998	NA

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

If you are filing claims electronically please contact our Electronic Data Interchange (EDI) department at (803) 788-9751 to update your EDI Enrollment Form.

If we may be of further assistance please call our Medicare Part B Customer Service Center at (803) 788-5568. A customer service representative will assist you.

Sincerely,

Mitchell McAllister
Medicare B Provider Certification



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 20 2002

Hugh S. Thompson, M.D.
2011-C Loop Road
Florence, South Carolina 29501

Dear Dr. Thompson:

Re: OI Case File No. 4-95-40434-9

Your request for reinstatement of your eligibility to participate as a provider of services covered by the title XVIII (Medicare) program has been approved. The reinstatement is effective with the date on this notice.

We have notified the appropriate State agencies of this action. However, the States are not obligated to reinstate you to their programs if they have imposed a longer period of exclusion under their own authority.

We recommend that you contact the Medicare carrier to determine your options for participating in that program.

Sincerely yours,

M. Joanne Lashan
Reviewing Official
Health Care Program Exclusions
Office of Counsel to the Inspector General

cc:
Regional Inspector General
for Investigations, Atlanta

870716210801



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

05/30/07

Pee Dee Health Care PA
3400 West Avenue
Columbia, SC 29203-6901

RE: Overpayment \$208,821.03
Supplier #: 1724
AR: 88000010055757

JUN 07

Dear Provider:

This is to let you know that you have received Medicare payment in error, which has resulted in an overpayment to you. This letter provides detailed information concerning each claim involved in the overpayment.

TriCenturion, a Program Safeguard Contractor (PSC), completed a review of claims submitted under the above referenced provider / group numbers and paid by Medicare. TriCenturion determined that you received payments in error, resulting in an estimated overpayment to you of \$208,821.03.

It has been determined that Dr. Thompson was sanctioned by the Office of Inspector General from 5/21/95 to 6/28/97, pursuant to § 1128(b)(4) of the Social Security Act, License Revocation or Suspension. TriCenturion's review of claims determined that 3 claims for Medicare payment were submitted while Dr. Thompson was sanctioned. During the sanction period, Part B Medicare claims for dates of service from 10/11/01 - 12/10/01 were paid to you. Please reference the enclosed worksheet that provides a listing of the claims. Along with our claim payment determinations, we made limitation of liability decisions for the denial of the services subject to the provisions of §1879 of the Social Security Act.

Section 1870 of the Social Security Act 42 CFR 405.350-359 permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. We have made the determination that you were "with fault" in causing or accepting the payment.

If you disagree with this overpayment decision you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter.

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3193
A CMS Contracted Intermediary and Carrier

**MEDICARE**

Part A Intermediary
Part B Carrier
DME Regional Carrier

Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

Medicare Part B Appeals
P.O. Box 100190
Columbia, SC 29202-3183

Please understand that a request for a redetermination will not alter the overpayment request until a final decision has been determined as to whether the overpayment is affirmed or withdrawn. Should the appealed decision be in your favor, our office will refund any money collected from you.

Please send a check in the amount of \$ 208,821.03 with a copy of this letter in the enclosed pre-addressed envelope by 06/28/2007:

Medicare Part B
PO Box 100183
Columbia, SC 29202-3183

For overnight delivery please make check out to Medicare Part B, but send to:

Palmetto GBA-Part B Accounts Receivable (AG-342)
2300 Springdale Drive
Building One
Camden, South Carolina 29020

In accordance with 42 CFR 405.378 simple interest at the rate of 12.375 % will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30 day period that payment is not made on time. Thus if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. See enclosure for details. Any repayment plan, where one is approved, would run from the date of this letter.

If payment in full is not received by 6/28/07, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withheld should not occur on 07/08/07 you must notify Palmetto GBA within 15 days from the date of this

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3183
A CMS Contracted Intermediary and Carrier

**MEDICARE**

Part A Intermediary
Part B Carrier
DME Regional Carrier

notice. We will review your documentation, but will not delay the recoupment. This is not an appeal of the overpayment determination.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy petition please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If this payment has already been refunded to our office for provider 1724, please complete the following information and return this letter to us in the enclosed envelope.

Check Number: _____
Check Date: _____
Check Amount: _____

Questions regarding the payment of this overpayment may be directed to (803) 735-1034, extension 31643.

Sincerely,

Mary Palejohn
Palmetto GBA Part B Accounts Receivable
Enclosure

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3193
A CMS Contracted Intermediary and Carrier

TONY R. MEGNA
ATTORNEY-AT-LAW
1815 FULMER ROAD
BLYTHEWOOD, SOUTH CAROLINA 29016
TELEPHONE: 803-799-1700
tony.megna@schar.org

June 7, 2007

Palmetto GBA – Part B Accounts Receivable (AG-342)
2300 Springdale Drive
Building One
Camden, SC 29020

Re: Supplier number: 1724
AR: 88000010055757

REQUEST FOR WITHHOLD NOT TO OCCUR AND, ALTERNATIVELY,
REQUEST FOR PAYMENT PLAN

Dear Sirs:

I represent Pee Dee Health Care, P.A. in the above-captioned matter. Please be advised that I received your letter dated May 30, 2007 on June 7, 2007. Among other things, the letter stated that Pee Dee Health Care, P.A. should advise you if there is any reason to believe that that future payments to Pee Dee Health Care, P.A. should not be withheld nor immediate demand for payment made until the entire matter resolved.

I respectfully request you reconsider your decision to seek immediate repayment of the \$208,821.03 you have demanded because of the following:

1. **PRIOR to allowing Dr. Thompson to provide services to any Medicare beneficiary, Pee Dee Health Care, P.A. obtained written confirmation from Palmetto GBA that Dr. Thompson had a current Medicare billing number and was an active provider with an active billing number in the Medicare program as of December 8, 1998. This information came from the carrier for Part B claims in South Carolina – Palmetto GBA. We have included a copy of the letter from Palmetto GBA as Exhibit A. The letter is dated December 8, 1998, and states that Dr. Thompson's Medicare provider number was effective December 8, 1998 with no expiration period and further states that "[Palmetto GBA] has approved and assigned a provider billing number to" Dr. Hugh Thompson.**

Thus, no recovery of the alleged overpayment can take place pursuant to the exceptions to payment adjustment as detailed in 42 U.S.C. 1395gg.

2. The last claim amount for which you are seeking repayment occurred over six years ago. The Medicare Act contains an express statute of limitations that prohibits any payment against a physician that took place more than six years before the present. 42 U.S.C. 1320a-7a(c)(1): [... The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place.]
3. Recovery or adjustment would be against equity or good conscience for all the reasons stated herein, and particularly due to the fact that Pee Dee Health Care, P.A. relied on the Medicare contractor's [Palmetto GBA] written instructions that Dr. Thompson had been issued a Medicare provider that was effective December 8, 1998 with no expiration period. See 42 U.S.C. 405.355 (a).
4. Recovery or adjustment is deemed, as matter of law, to be against good equity and conscience as the determination that such overpayments was not paid until subsequent to the third year following the year in which notice of such payment was made. See 42 U.S.C. 405.355 (b). the "without fault" rule states that *a provider of services shall, in the absence of evidence to the contrary, be deemed without fault if the overpayment determination of the carrier is made subsequent to the third year following the year in which payment was made.* Instead of considering the specific date of service, this rule considers the calendar year in which the service took place. the current matter, the services took place prior to December 10, 2000,—so 2001 was the first year after payment, 2002 the second, 2003 the third and 2004 the fourth, 2005 the fifth, 2006 the sixth, and 2007 the seventh. Consequently, Pee Dee Health Care, P.A. is deemed without fault and the overpayments cannot be recovered.

I would appreciate you responding to this letter at your earliest convenience and advising of further avenues to seek delay of repayment until these matters are resolved in their entirety. Obviously, everyone at Pee Dee Health Care, P.A. is distressed over these matters and trust the matters can be resolved as soon as possible. In the event you decide to continue to seek immediate repayment, Pee Dee Health Care, P.A. respectfully requests that you provide a repayment plan of the longest duration possible. The funds you have requested be repaid are significant and will impede the ability of Pee Dee Health Care, P.A. to effectively operate.

With kind regards, I remain

Sincerely yours,

Tony R. Megna



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

DATE: December 8, 1998

Hugh S. Thompson, M.D.
Pee Dee Health Care, Inc.
201 Cashua St.
Darlington, SC 29532

Dear Dr. Thompson:

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and/or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and/or practitioner(s). The member(s) listed below have the participation status of the group practice. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Provider Name	Provider Number	Effective Date	Expiration Date
Hugh Thompson	D993211724	October 26, 1998	NA

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

If you are filing claims electronically please contact our Electronic Data Interchange (EDI) department at (803) 788-9751 to update your EDI Enrollment Form.

If we may be of further assistance please call our Medicare Part B Customer Service Center at (803) 788-5568. A customer service representative will assist you.

Sincerely,

Mitchell McAllister
Medicare B Provider Certification

June 15, 2007

BY HAND DELIVERY AND CERTIFIED MAIL

Medicare Part B Appeals
P.O. Box 100190
Columbia, South Carolina 29202-3190

Re: Request for Redetermination and Withhold Objection

To Whom it May Concern:

I am an attorney with Nexsen Pruet, LLC and we represent FirstChoice Healthcare ("FirstChoice"). FirstChoice received an overpayment demand letter ("Overpayment Letter") on May 30, 2007. The Overpayment Letter, which is attached as Exhibit A, stated that FirstChoice has received an overpayment by Medicare in the amount of \$101,650.14. Pursuant to the terms of your letter and the applicable statutes and regulations, please allow this letter to serve as FirstChoice's request for redetermination of the overpayment determination and a formal request that the withhold not be implemented.

Charleston

Charlotte

Columbia

Greensboro

Greenville

Hilton Head

Myrtle Beach

Request for Redetermination

As the basis for this alleged overpayment, the Overpayment Letter states that FirstChoice received Medicare Part B payments for services provided by Dr. Hugh Thompson from March 31, 1996 to June 20, 2002, during which time, Dr. Thompson was excluded from participating in the Medicare program.

The excluded provider designation was imposed as a result of the suspension of Dr. Thompson's license to practice medicine after Dr. Thompson refused to pay a fine owed to the South Carolina Board of Medical Examiners. Dr. Thompson paid this fine and his license was reinstated in 1998. Unfortunately, Dr. Thompson was unaware that he was required to file any additional paperwork and thus failed to complete the appropriate paperwork to remove his name from the OIG's excluded provider list. Thus, while he had satisfied all the necessary criteria to obtain reimbursement from Medicare and obtained the appropriate permission to do so, he was still erroneously listed as an excluded provider.

1441 Main Street
Suite 1500 (29201)
PO Drawer 2426
Columbia, SC 29202
www.nexsenpruet.com

T 803.540.2128
F 803.253.8277
E W.Jackson@nexsenpruet.com
Nexsen Pruet Adams Kleemeier, LLC
Attorneys and Counselors at Law

NPCOL1:1110150.1-LT-(PWJ) 028853-00007

Dr. Thompson and FirstChoice first became aware of Dr. Thompson's presence on the OIG's excluded provider list in 2002 when Dr. Thompson referred a Medicare patient for physical therapy in North Carolina. The practice manager of the physical therapy practice called FirstChoice and indicated that she received a letter from HCFA that Dr. Thompson was excluded from Medicare effective March 31, 1996. Up and until the point the physical therapy practice manager notified FirstChoice of Dr. Thompson's excluded provider status, Dr. Thompson and FirstChoice had no knowledge of any such designation.

In response to the practice manager's discovery, FirstChoice called Palmetto GBA and spoke to Tina Houser (803.786.1034, ext. 34620), who informed FirstChoice that Dr. Thompson was in good standing with Medicare and that FirstChoice could bill and be reimbursed in South Carolina. Dr. Thompson had further conversations with the OIG and HCFA and was sent a reinstatement form in February 2002, which indicated that FirstChoice could not participate in Medicare or Medicaid until the reinstatement was completed. FirstChoice again called Palmetto GBA and was told that Dr. Thompson's Medicare number was active and that FirstChoice could bill Medicare for Dr. Thompson's services.

In July 2002 FirstChoice received an Explanation of Benefits denying payment on all of Dr. Thompson's patients with an explanation that he "was not certified for the procedure/service on the date of service". FirstChoice contacted Palmetto GBA once again and this time was informed that Dr. Thompson was excluded from Medicare from March 1996 until June 2002. FirstChoice was also told that repayment of Medicare funds received during that time would be owed and that FirstChoice would be turned over to the fraud investigation department.

Please note that in 1998 when Dr. Thompson began part-time work for FirstChoice, Dr. Thompson filed an 855-I and an 855-R form, both of which were accepted. Additionally, in November 2000 FirstChoice opened a satellite office which received a group Medicare number and to which Dr. Thompson was allowed to reassign his benefits under the 855-R. Further, in 2001 Dr. Thompson filed and received Railroad Medicare Provider status. At the time these applications were submitted, neither Dr. Thompson nor FirstChoice were aware that Dr. Thompson was on the excluded provider list. Thus, there was no reason for Dr. Thompson or FirstChoice to doubt Dr. Thompson's status as an approved Medicare provider upon the approval of the above-referenced applications. Prior to Dr. Thompson's employment with FirstChoice, Dr. Thompson had worked at two other medical clinics, Fowler Health Clinic and The Pee Dee Group, both of which had submitted the appropriate paperwork to PalmettoGBA and had received notification that Dr. Thompson was in good standing and reassignment of benefits to their respective

group numbers were permitted by PalmettoGBA. FirstChoice was provided with copies of the acknowledgement of reassignment of benefit when Dr. Thompson began his employment with FirstChoice.

In 2004, we represented FirstChoice in discussions with Jennifer Aldrich in the U.S. Attorney's Office regarding this matter. At that time, Ms. Aldrich informed us that there was no intention to seek repayment from FirstChoice due to Dr. Thompson's designation as an excluded provider. At that time, due to the representation of the U.S. Attorney's Office, FirstChoice and Dr. Thompson considered the matter closed.

Due to the facts outlined above, CMS, through Palmetto GBA, may not seek repayment due to the doctrine of equitable estoppel. Federal law is clear that the Government may be estopped if there was affirmative misconduct by a Government agent. In this case, there were multiple occasions where Dr. Thompson and FirstChoice made inquiries regarding Dr. Thompson's status and on almost every occasion, they were informed that he was eligible to participate. When they were informed that he was not eligible, Dr. Thompson and FirstChoice took appropriate remedial action and willingly participated in Government investigations regarding the matter.

FirstChoice and Dr. Thompson relied on the Government's actions and began and continued billing Medicare for services provided by Dr. Thompson. The CMS Fiscal Intermediary Manual and OIG guidance mandate that carriers confirm that the provider is not excluded from the Medicare program when reviewing provider enrollment forms. This is a key component of ensuring that the applicant is eligible for a Medicare provider number. When Dr. Thompson's 855-I and 855-R were accepted, CMS committed affirmative misconduct as it should have alerted Dr. Thompson and FirstChoice that he was excluded. Because his exclusion resulted from a paperwork error on the part of PalmettoGBA, Dr. Thompson could have quickly remedied this situation. Instead, his applications were approved and he was issued a provider number. In addition, through the U.S. Attorney's Office, the Government has already investigated this matter and determined that no repayment was necessary.

In addition to the fact that the previous actions by the Government should estop it from instituting this overpayment collection proceeding, it also documents that FirstChoice was without fault and therefore, collection of this overpayment should be waived. Dr. Thompson was approved as a Medicare provider by CMS and was issued a provider number. As outlined above, Dr. Thompson and FirstChoice relied on CMS when it billed for Dr. Thompson's services. Had CMS, PGBA or any other entity informed Dr. Thompson or FirstChoice that Dr. Thompson was listed as

an excluded provider, it would have remedied the technical error and this matter would have never arisen.

The reason for Dr. Thompson's sanction was not related to any healthcare fraud. At all times Dr. Thompson was a licensed physician in good standing while providing covered services to the Medicare beneficiaries. All services provided were medically necessary and have not been objected to otherwise. Therefore, we believe this overpayment demand is in error and should be reversed.

Objection to Withhold

In the Overpayment Letter, it states that PGBA will withhold payments to FirstChoice if the overpayment is not paid in full by June 28, 2007. It further states FirstChoice many notify PGBA within fifteen days (15) from the date of the Overpayment Letter. Today, June 14 is the fifteenth day. Pursuant to the Overpayment Letter and 42 C.F.R. 405.374, we request that no future Medicare funds be withheld based on the substantive arguments outlined above.

We spoke with Louise Custard in the Medicare Part B Accounts Receivable office regarding this matter as well. Ms. Custard stated that if a request for redetermination was received prior to the withhold date in the Overpayment Letter, no withhold would implemented. Further, because we feel this overpayment demand is in error and are appealing it pursuant to this letter, it would inequitable to withhold payments to FirstChoice until a final determination is made.

42 U.S.C.A. requires that PGBA respond to the withhold objection within fifteen (15) days from the receipt of this letter. We look forward to the response. Should you have any questions, or need any further information, please contact me.

Sincerely,

Wes Jackson



Tony R. Megna <tmegna@gmail.com>

Hugh Thompson

Mark Matthews <nebendermm@yahoo.com> Tue, Jul 10, 2007 at 4:41 PM
To: tony@pdhc.com

When I talked to Dean Banks about Hartsville he also agreed to send the information on the Hugh Thompson case. He wanted us to email what you have done. Where and what can I send to him?

Also he said he was told that Medicare in the past has not withheld payments during an appeal although their policy says they will. They have not sent any money and have not had any withholds as of yet.

Mark

No need to miss a message. Get email on-the-go with Yahoo! Mail for Mobile. Get started.
<http://mobile.yahoo.com/mail>





Tony R. Megna <tmegna@gmail.com>

Thompson info

1 message

Tony R. Megna

Wed, Jul 11, 2007 at 10:05

<tmegna@gmail.com>

AM

To: wdbanks@aol.com

Cc: Mark Matthews <nebendermm@yahoo.com>

Dean-

Per Mark Matthews conversation with you. I have attached a copy of the re- determination letter sent by PDHC to PGBA. Please feel free to call me if you have questions and I appreciate you sharing with us information you have provided PGBA.

--

Thanks, Tony

Please send all written correspondence to:

Tony R. Megna, Esquire

1815 Fulmer Road

Blythewood, South Carolina 29016

tony@pdhc.com

Office telephone: 803.799.1700

Facsimile: 803.753.9004

This message is intended for the use of the person or entity to

which

it is addressed and may contain information, including legal and/or health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent

responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this in

error, please notify us immediately and destroy the related message.

Thank you.



Copy to Dean Banks 071007.pdf
500K



**FirstChoice
Healthcare, Inc.**

October 17, 2007

RECEIVED

OCT 25 2007

NEXSEN PRUET, LLC

Southern ALJ Field Office
100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100

RECEIVED

OCT 29 2007

OMHA - Miami

RE: Medicare Appeal No. 1-192761454
Appellant: FirstChoice Healthcare, PC ("FirstChoice")
1920 Second Loop Rd.
Florence, SC 29501-6123
Provider # 6672
Invoice # 00010025757
Overpayment amount: \$101,650.14

To Whom It May Concern:

Please allow this letter to name Nexsen Pruet, LLC, a Columbia, South Carolina law firm, to act as my appointed representative to deal with all matters relating to the appeal of the above-referenced matter. By signing below, I hereby consent to the Administrative Law Judge, or any other party associated with the above-referenced appeal, to contact and discuss any matters related to such appeal with Nexsen Pruet. I authorize Nexsen Pruet to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal. If you have any questions, please do not hesitate to contact me.

Sincerely,

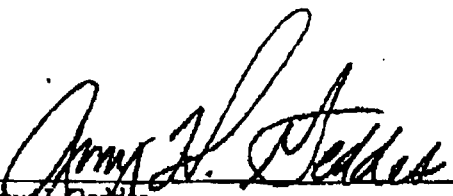
Dean Banks, President
FirstChoice Healthcare, PC ("FirstChoice")
1920 Second Loop Rd.
Florence, SC 29501-6123

Dated: 10/17/07

Acceptance of Appointment:

I, Amy Geddes, attorney with Nexsen Pruet, LLC, accept the above appointment.

1920 Second Loop Road • Florence, SC 29501
843-678-9777 • Fax 843-665-2814



Amy H. Geddes
Naxson Pruet, LLC
1230 Main Street, Suite 700
Columbia, South Carolina 29201

Dated: 10/18/07

cc: Q2 Administrators, LLC
P.O. Box 183092
Columbus, OH 43218-3092

LAW OFFICE
PAULLING & JAMES, LLP

ALBERT L. JAMES, III
JOHN JAY JAMES, II

T. DUDLEY PAULLING
(1896 - 1973)
ALBERT L. JAMES, JR.

P. O. BOX 507
DARLINGTON, S. C.
29540

TELEPHONE
843-393-3881
FAX
843-393-6889
EMAIL
pjlawyer@bellsouth.net

July 9, 2010

HAND-DELIVERED

RE: Pee Dee Health Care, PA vs Estate of Hugh S. Thompson, Jr.

Benjamin R. Matthews, Esquire
Matthews and Megan, P.A.
3400 West Avenue
Columbia, S. C. 29203

Dear Ben:

As a supplemental response to the Defendant's Response to Plaintiff's Request for Production, I enclose the following:

1. Decision of Don W. Joe. Please note that I do not have at this time the attachments mentioned in that decision and I am trying to get them.
2. Summary of events and observations believed to have been prepared by Hugh S. Thompson, Jr. May 28, 2004.
3. Summary of events prepared by Dean Banks (date unknown).
4. SC Board of Medical Examiners file for Hugh S. Thompson, Jr.
5. Statement of Hugh S. Thompson, M.D. for the NC Physicians Health Program dated January 25, 2008.
6. TriCenturion letter to Pee Dee Health Care dated April 24, 2007.
7. Personal income tax returns for Dr. Thompson for 1998, 1999 and 2001.

The letters mentioned in Paragraphs 5(b) and 5(c) of our original Response are in the Medical Examiners file. The information mentioned in Paragraph 10(a) of our original Response is in the Medical Examiners file.

As with prior discovery responses, nothing herein should be or may be construed as a waiver of the right to object to incompetent testimony or evidence as provided by the Deadman Statute, SC

July 9, 2010

Page No. 2

Code Ann. §19-11-20. Defendant reserves all rights to object to evidence and testimony as provided therein.

Very truly yours,

PAULLING & JAMES

JJJH:psb
Enclosures

BY

A handwritten signature in black ink, appearing to read "Jay James". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Matthews and Megna, LLC

Attorneys and Counselors at Law

3400 West Avenue

Columbia, SC 29203

TELEPHONE: 803-799-1700

E-mail: tmegna@gmail.com

July 8, 2011

HAND-DELIVERED

The Honorable J. Michael Baxley

531 East Carolina Avenue

Hartsville, SC 29550-4311

Re: Estate of Hugh S. Thompson, Case No: 10-CP-16-0332

Matthews and Megna, LLC

Attorneys and Counselors at Law

3400 West Avenue

Columbia, SC 29203

TELEPHONE: 803-799-1700

E-mail: tmegna@gmail.com

July 8, 2011

HAND-DELIVERED

**The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311**

Re: Estate of Hugh S. Thompson, Case No: 10-CP-16-0332

Dear Judge Baxley:

I am in receipt of your letter dated June 23, 2011. I genuinely appreciate you taking the time to respond to my continuing concerns that the Plaintiff has been denied the opportunity to complete discovery to properly present its' case, and has been denied the opportunity to complete discovery in order to properly present its' Motion for Summary Judgment as well as to oppose the pending motions of the Defendant that the Court has indicated it will address on July 19. As you know, the Plaintiff's continuing requests to complete the taking of depositions, and to complete discovery that occurs as a result of those depositions, have been delayed though no fault of the Plaintiff.

Part 1

1. On January 27, 2011, the Plaintiff noticed the depositions of the personal representatives of the estate for February 10, 2011. [See attached]. The Defendants replied that the taking of the depositions was premature until the Court ruled on the Motion to Disqualify.
2. On February 24, 2011, the Defendant wrote the Court requesting that the Motion to Disqualify be heard and determined first. [See attached].
3. The Plaintiff filed returns to the Motions of the Defendant as well as in support of its' Motion for Summary Judgment and the Plaintiff advised and informed the court that discovery, other than depositions, had been completed. [See attached].
4. By order dated March 7, 2011, this Court continued all pending motions of all parties. [See attached].

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 2 of 12

5. On March 16, 2011, the Motion to Disqualify was heard by the court, the court granted the motion of the Defendant disqualifying Plaintiff's choice of counsel, the court orally ruled that Plaintiff's choice of counsel was effective immediately upon its' oral ruling on March 16, and the court continued all outstanding motions of the parties. The Court requested counsel for the Defendants to prepare a written proposed order.
6. On March 22, 2011, the attorneys for the Defendant e-mailed the Court a proposed order based on the Court's determination at the hearing of March 1, 2011 to grant the Defendant's Motion for Disqualification of Plaintiff's choice of counsel.
7. On April 19, 2011, the Court entered a written order disqualifying Plaintiff's choice of counsel. [See attached].
8. The Plaintiff subsequently filed its Rule 59(e) Motion requesting the Court to reconsider its order disqualifying Plaintiff's counsel of choice. [See attached]. Plaintiff's 59(e) motion stayed the time for appeal of the court's order disqualifying Plaintiff's choice of counsel, but did not stay the order of the Court disqualifying Plaintiff's choice of counsel. The Court's ruling on the disqualification issue has prevented Plaintiff's choice of counsel from participating in the case since the March 16th hearing, and thus has prevented participation in any matter other than the Rule 59(e) motion requesting the Court to alter or amend its order disqualifying Plaintiff's choice of counsel.

The Plaintiff has attempted continuously since January, 2011 to have the depositions of the personal representatives of the Defendant taken in support of all its' motions in order to determine what additional discovery may be needed. It is neither fair nor reasonable to expect the Plaintiff to argue its' Motion for Summary Judgment nor is it fair or reasonable to expect the Plaintiff to defend against the motions of Defendant, including its' Motion for Summary Judgment, while:

1. an outstanding order of this Court has disqualified Plaintiff's choice of counsel from representing Plaintiff in these matters since March 16, 2011.
2. By the time of the hearing on July 19 this court has scheduled for the Plaintiff's Rule 59(e) motion as to the disqualification matter, it will have been four months since the Plaintiff's choice of counsel has had the opportunity to actively participate in the case as a result of the March 16th order of this Court. Moreover, the Plaintiff has not had the opportunity to pursue its' appellate rights as this Court has not ruled on Plaintiff's outstanding Rule 59(e) motion. Our Supreme Court has held:

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 3 of 12

We conclude an order granting a motion to disqualify a party's attorney in a civil case affects a substantial right and may be immediately appealed under Section 14-3-330(2). Such an order implicitly falls within the statutory definition of a substantial right under Section 14-3-330(2)(a). The right to be represented by an attorney of ones choosing is one of those rare orders which, in effect, could determine the action and prevent a judgment from which an appeal might be taken, or could discontinue an action due to the potential impact on both the attorney-client relationship and the overall litigation and trial of the case. Moreover, the right to be represented by ones preferred attorney is closely related to the right to a particular mode of trial, a well-established substantial right.

Deprivation of the right to ones preferred attorney would affect the attorney-client relationship, which is extremely important in our adversarial system. Furthermore, an appeal after final judgment and a new trial, if granted, would not adequately protect a party's interests because it would be difficult or impossible for the affected party or the appellate court to ascertain by any objective standard whether prejudice resulted from the disqualification.

We further conclude, as we have with regard to the right to a particular mode of trial, an order granting a motion to disqualify a party's preferred attorney *must* be immediately appealed or any later objection in a subsequent appeal will be waived. *Cf. Flagstar Corp.*, 341 S.C. at 72, 533 S.E.2d at 333 (party is required to immediately appeal if denied a mode of trial to which he is entitled as a matter of right, and failure to do so forever bars appellate review of the issue).

Hagood v. Sommerville, 362 S.C. 191, 194, 607 S.E.2d 707, 708 (2005) (citing *Mid-State Distribs., Inc. v. Century Imps., Inc.*, 310 S.C. 330, 335, 426 S.E.2d 777, 781 (1993); S.C. Code Ann. § 14-3-330(1) (1976); Rule 72, SCRCF; and Rule 201(a), SCACR).

Therefore, it is imprudent and unjust for this Court to require the Plaintiff to argue its Motion for Summary Judgment or to defend against the motions of the Defendant under such circumstances.

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 4 of 12

PART 2

In addition to the foregoing, the undersigned is troubled by the Court's remark in its' recent letter that Rule 11, S.C.R.Civ.P. requires a reasonable basis for the filing of a motion, the insinuation being Plaintiff's pending Motion for Summary Judgment is not adequately supported under the facts of the case. The record demonstrates the opposite. The Defendant filed its' answer making several admissions that, in and of themselves, provides more than a reasonable basis for the filing and granting of Plaintiff's Motion for Summary Judgment. As our Supreme Court held in *Father v. South Carolina Dep't of Soc. Servs.*, 353 S.C. 254, 578 S.E.2d 11 (2003), the standard for making such observations is whether a party reasonably believes that under those facts his claim may be valid under the existing or developing law. I have noted many of the admissions made by the Defendant in its' original answer filed with the Court prior to the filing of the Plaintiff's Motion for Summary Judgment. Moreover, Rule 56(a) specifically allows for the filing of the Motion for Summary Judgment, with or without, supporting affidavits in his favor upon all or any part thereof. The Plaintiff, however, supplied over 350 pages of supporting documents in its filings in this Court dated March 11, 2011, including multiple affidavits supporting its' position. The Defendant, on the other hand, has produced no evidence to the contrary. To be fair, the Defendant has claimed the Plaintiff could have prevented the decedent's misconduct, a notion that that is legally ineffective and factually inaccurate. *Champion*, supra.

Facts in Defendant's Answer Supporting Plaintiff's Motion for Summary Judgment

1. The Defendant filed its' answer on to the Defendant's June 17, 2010. The answer of the Defendant admitted that:
 - a. The relationship of Decedent with Plaintiff was such that Decedent "was bound to act in good faith and with due regard to Plaintiffs' interest." [Page 4, 21 of Defendants Answer filed June 17, 2010].
 - b. The relationship of Decedent with Plaintiff was such that Decedent had a pecuniary interest since he was paid by Plaintiff as a physician to provide medical services. [Page 5, ¶25 of Defendants Answer filed June 17, 2010].
 - c. The relationship of Decedent with Plaintiff was such that Decedent "was bound to act in good faith and with due regard to Plaintiffs' interest." [Page 4, ¶ 21 of Defendants Answer filed June 17, 2010].
 - d. The relationship of Decedent with Plaintiff was such that Decedent "was obligated to communicate truthfully with Plaintiff. Defendant would admit that

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 5 of 12

the Decedent had not been reinstated by the Office of Inspector General at the time he worked for Plaintiff..." [Page 5, ¶ 26 of Defendants Answer filed June 17, 2010].

- e. The relationship of Decedent with Plaintiff was such that Decedent "was obligated to communicate truthfully with Plaintiff. Defendant would admit that the Decedent had not been reinstated by the Office of Inspector General at the time he worked for Plaintiff..." [Page 5, ¶ 26 of Defendants Answer filed June 17, 2010].
- f. The Decedent's medical license was suspended by the SC Board of Medical Examiners on or about May 31, 1994 and that his license to practice medicine was reinstated on or about April 14, 1998. [Page 2, ¶ 11 of Defendants Answer filed June 17, 2010].
- g. On or about March 31, 1996, the Decedent was disbarred from the Medicare program by the Office of Inspector General who oversees physician participation in the Medicare program. [Page 2, ¶ 10 of Defendants Answer filed June 17, 2010].
- h. On or about October 26, 1998, the "Decedent entered into a relationship with Plaintiff to provide medical services to its patients, including Medicare patients." [Page 3, ¶ 12 of Defendants Answer filed June 17, 2010]. [Page 8, ¶¶ 61 and 62 of Defendants Answer filed June 17, 2010].
- i. To the extent that Decedent was an employee of Plaintiff, Decedent admits that a duty of loyalty to Plaintiff was owed." [Page 6, ¶ 30 of Defendants Answer filed June 17, 2010].
- j. Following the Decedent's disbarment from Medicare, by the Medicare Office of Inspector General, "provisions of federal law provide that a suspension of Medicare privileges [i.e., the Decedent's disbarment from the Medicare program in 1996] continues until [the Decedent was] reinstated by the Office of Inspector General [of the Medicare program]." [Page 3, ¶ 12 of Defendants Answer filed June 17, 2010].
- k. In 1998, the Decedent failed to seek reinstatement to the Medicare program by the Medicare Office of Inspector General. [Page 2, ¶ 11, Answer filed June 17, 2010].

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 6 of 12

- l. Defendant admits a Medicare provider application and an 'reassignment of benefits [application] were prepared [with Decedent's signature on the certifications affixed by Decedent – see Exhibits A and B attached hereto and incorporated herein by reference] so as to permit Decedent to treat Medicare patients and for Plaintiff to receive payments therefore." [Page 2, ¶ 9 of Defendants Answer filed June 17, 2010].
- m. "Defendant admits that Decedent had a duty to be truthful on any and all applications, certifications, and affirmations to Medicare and/or Plaintiff." [Page 6, ¶ 34 of Defendants Answer filed June 17, 2010].
- n. "Defendant admits so much of ¶10 of the Complaint as alleges that Palmetto GBA [the Medicare representative that oversees the payment of claims for the Medicare program in South Carolina] issued to Decedent Medicare provider number D993211724..." See Exhibit C attached hereto. [Page 3, ¶ 12 of Defendants Answer filed June 17, 2010].
- o. On or about June 17, 2007, the Plaintiff received a demand letter from Medicare that "would have had a content similar to that set forth in paragraph 12 of the Complaint." [Page 3, ¶ 14 of Defendants Answer filed June 17, 2010]. Paragraph 12 of the Plaintiff's Complaint stated as follows:

On or about June 7, 2007, Plaintiff received a letter dated May 30, 2007 from Palmetto GBA in regard to medical services provided by Decedent on behalf of Medicare beneficiaries for the dates of October 26, 1998 to December 10, 2001.

The letter stated, among other matters:

- I. That the Decedent had been suspended (sanctioned) from participation in the Medicare program during the time periods March 31, 1996 to June 20, 2002.
- II. That during the sanction period ..., Medicare payments were paid to Plaintiff for services Decedent provided to Medicare beneficiaries because the Decedent had completed an 'assignment of benefits' to Plaintiff. However, Decedent omitted any reference in regard to this suspension from the Medicare program.

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 7 of 12

III. That Plaintiff was liable for the funds paid regardless of the fact that Plaintiff had no knowledge of the matter and that Dr. Thompson had provided both Plaintiff and Medicare with false information.

IV. That the estimated overpayment made by Medicare for patients provided by Decedent during the time he was suspended from the Medicare program was \$208,821.03 plus interest at 12.375%.

The letter of June 17, 2010 has been previously submitted to the Court as Exhibit X.

2. "Decedent ... erroneously believed that filing a provider application to Palmetto GBA (a Medicare contractor) was sufficient to reinstate Decedent's status as a Medicare provider." [top of Page 3, ¶ 11 of Defendants Answer filed June 17, 2010 and Exhibit E]. [The Defendant does not explain how it came to this conclusion as it is a statement by the deceased, making the need for depositions to explore this and other related matters.]
3. Defendants have no information in their possession in regard to the allegations of ¶32 of the Plaintiff's Complaint, and therefore deny same. Paragraph 32 of the Plaintiff's Complaint states:

Decedent breached his duty to Plaintiff:

- a. By act of certifying to Plaintiff personally and on his Medicare applications that he was truthful
- b. By omission failing to inform Plaintiff of the falsity of his affirmations and certifications that he was barred from medically treating Plaintiff's Medicare patients

The Plaintiff, however, has provided numerous unopposed documents to this Court in support of the allegations made in paragraph 32. Please see documents A, B, E, F, O, FF, Y, Z, AA, BB, CC, DD and EE previously filed with this Court, and attached hereto.

4. Any and all claims, however posed by Defendant, that Plaintiff could have 'prevented' the Decedent's wrongdoing and/or the negative consequences of the Defendant's

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 8 of 12

admitted misconduct have been addressed by our appellate courts, and rejected. See *Wilms Trucking v. JW Construction*, 442 SE 2d 197(1994) citing *Morgan v. Crowley*, 91 Ga.App. 58, 85 S.E.2d 40 (1954) (a party cannot take advantage of his own default in the performance of a contract); 17A Am. Jur.2d *Contracts* § 621 (1991) (where a contract is not performed, the party who is guilty of the first breach is generally the one upon whom all liability for the nonperformance rests). Cf. *Champion v. Whaley*, 280 S.C. 116, 311 S.E.2d 404 (Ct.App.1984) (party to a contract cannot take advantage of the uncertainty created by his own wrongdoing).

Further, Exhibit "E" [see attached] reasonably demonstrates that the Decedent admitted he failed to provide Medicare the information needed to have him reinstated to the Medicare program after his disbarment. The affidavits submitted by Plaintiff [Exhibits Y, Z, AA, BB, CC, DD and EE] [see attached], and Decedent's own statement further indicate Dr. Thompson never informed Plaintiff that he was 'disbarred' from the Medicare program both prior to, during, and after his employment with Plaintiff. As a matter of settled law in South Carolina, Decedent's estate cannot now assert the Plaintiff could have 'prevented' the matter by taking additional actions to save the Decedent from his own wrongdoing. As noted above, our Court of Appeals has stated the Defendant's assertion of 'prevention' as a defense is not allowed or recognized under South Carolina law. *The Huffines Co., LLC v. Lockhart*, 617 SE 2d 125 (2005).

Part II

The Plaintiff has previously requested this Court consider recusing itself from hearing the case because of pending litigation in Florence County concerning judges that this Court regular associates with as a part of its' duties with neighboring jurisdictions. A copy of the Plaintiff's most recent amended complaint is attached hereto. The complaint involves matters and parties which this Court regularly encounters when sitting in Florence County. While it may be argued that recusal is not required under the canons of Judicial Conduct, Canon 3(E) of the Code of Judicial Conduct counsels that recusal is reasonable and appropriate in matter such as the current when the court and the parties are so intertwined.

Therefore, the Plaintiff requests this Court to act first upon its' pending Rule 59(e) motion and/or to allow Plaintiff's requests choice of counsel to make a formal motion of recusal in order that the matter can be properly addressed if the Court determines a formal motion is preferable to recusal on the court's own initiative.

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 9 of 12

CONCLUSION

The Plaintiff's position remains straightforward and consistent. The Plaintiff:

- a. has not had the opportunity to pursue its' discovery rights, and respectfully requests, pursuant to Rule 56(f), S.C.R.Civ.P. (and the affidavit of the President of Plaintiff attached hereto and incorporated herein by reference) that the Court allow the completion of discovery prior to hearing any pending motions of the parties other than the Plaintiff's pending Rule 59(e) Motion to Reconsider,
- b. has not had the opportunity to pursue its' appellate rights as our Supreme Court has held it must do in order to preserve the issue of disqualification of counsel for review,
- c. has not had the opportunity to pursue any preparation of the case since the entry of this Court's order of disqualification of Plaintiff's choice of counsel since March 16, 2011,
- d. cannot act until this Court makes a final disposition of the Plaintiff's pending Rule 59(e) motion. Currently, Plaintiff's choice of counsel is in limbo as it has been since this Court's order of March 16. Consistent with our Supreme Court's directives of immediate appeal in such matters, Plaintiff does not wish to waive its' right to its' chosen choice of counsel. The Plaintiff is willing to waive oral arguments on the pending Rule 59(e) motion. If the Court grants the Plaintiff's motion, the Plaintiff requests it allow ninety (90) days to complete discovery. If the Court denies the Plaintiff's 59(e) motion, the Plaintiff requests the Court allow it the time set-forth under Rule 203(b)(1) to file its appeal as the Supreme Court has deemed necessary to preserve the issue. *Hagood*, supra. In the interim, Plaintiff maintains its' continuing objections to pending motions being heard [other than the Plaintiff's Rule 59(e) motion] until all discovery is complete. Fundamental concerns of fair play and due process necessitate such a reasonable result.
- e. submits this Court should recuse itself from hearing any further matters in this case on its own motion or allow Plaintiff's choice of counsel to file a motion requesting recusal for the reasons set forth hereinabove.

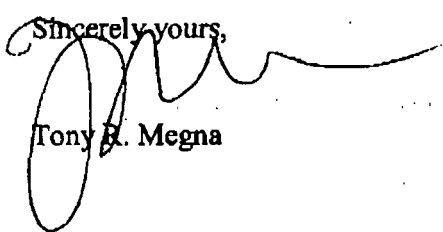
I will be in the Darlington area on July 19, and will be available at the Court's discretion both prior to and following the scheduled 4:00 p.m. hearing time. I will be in Washington the

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 10 of 12

week of July 11, 2011 but will make time for the Court, at its' convenience if you so desire, to hold a telephone conference or hearing. My goal is to be accommodate the Court's scheduling needs to any extent necessary to resolve these matters justly and appropriately. I request adequate notice to insure the privacy needed for a conference call. The Court can reach me on my mobile number [803.606.5983], and my email address [tmegna@gmail.com].

With kind regards, and respectfully, I remain

Sincerely yours,


Tony B. Megna

Cc:

John Jay James, Esquire
PO Box 507
Darlington, SC 29540
[attachments previously provided]

Renee Josey
1851 W. Evans Street, 4th Floor
Florence, SC 29501
[attachments previously provided]

The Honorable Scott B. Suggs
Clerk Of Court,
Darlington County
1 Public Square, Room B-4
Darlington, South Carolina 29532
[attachments included]

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 10 of 12

**STATE OF SOUTH CAROLINA
COUNTY OF DARLINGTON
IN THE COURT OF COMMON PLEAS**

Pee Dee Health Care, P.A.,

Plaintiff,

v.

Estate of Hugh S. Thompson,

Defendant.

10-CP-16-0332

**AFFIDAVIT IN SUPPORT OF RULE 56(F) REQUEST FOR COMPLETION OF
DISCOVERY**

I, Alexander H. Cohen, M.D., the President of Pee Dee Health Care, P.A., being duly sworn, state as follows:

1. I have read and reviewed the foregoing attached motion. The continuing requests of Plaintiff's counsel to complete discovery (including but not limited to the taking of the depositions of the Personal Representatives of the Defendant and such other discovery as needed) are reasonable, necessary, and essential to the opposition of the Plaintiff to the pending motions of Defendant before the Court for reasons including but not limited to the following:
 - a. the Defendant's refusal to participate in the taking of the depositions of the personal representatives by the Plaintiff prior to this Court's final determination of the Defendant's Motion to Disqualify the undersigned from representing the Plaintiff,
 - b. the Court's previous order disqualifying Plaintiff's choice of counsel, Tony R. Megna, from representing the Plaintiff in these matters, and thus effectively concluding the opportunity of the Plaintiff to complete discovery until the Court determines the Plaintiff's pending motion pursuant to Rule 59(e), S.C.R.Civ.P.

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 8, 2011
Page 11 of 12

- c. The SC Supreme Court's determination that choice of one's attorney in any action is a substantial right of a party, and that an order disqualifying counsel must be immediately appealed or any later objection in a subsequent appeal will be waived.
 - d. Plaintiff incorporates the communications attached hereto as exhibits evidencing the Plaintiff's prior requests to this Court and to the Defendants that depositions be allowed to be taken and discovery completed prior to the Court scheduling any hearing on all outstanding motions of the parties.
2. PDHC again requests this court to allow Mr. Megna to represent Plaintiff in these matters. Alternatively, Plaintiff requests this Court to allow sufficient time to appeal the order of the court disqualifying Mr. Megna to the SC Supreme Court.


Alexander H. Cohen, M.D.

Sworn to and subscribed before me this

7th day of July, 2011.


Notary Public for South Carolina

My commission expires: August 10, 2017

STATE OF SOUTH CAROLINA)
)
)
COUNTY OF DARLINGTON)

IN THE COURT OF COMMON PLEAS

Pee Dee Health Care, P.A.,)
)
Plaintiff,)
)
v.)
)
Estate of Hugh S. Thompson, M.D.)
)
Defendants.)
_____)

Case No. 10-CP-16-0332

NOTICE OF DEPOSITION

Pursuant to Rule 30 of the South Carolina Rules of Civil Procedure, by and through undersigned counsel, Plaintiff shall take the depositions of the representatives of the Estate of Hugh Thompson (Hugh S. Thompson, III, and Louise T. Dailey). Pursuant to Rule 34(b)(5), S.C.R. Civ.P., you are also requested to produce and all documents that have not been previously provided to Plaintiff in the course of discovery between the parties.

The depositions shall be held at the offices of Pee Dee Health Care, P.A, 102 Cashua Street, Darlington, SC 29532 beginning at 10:00 a.m., Thursday, February 10, 2011, and will continue until complete.

s/Tony R. Megna

Tony R. Megna, Esquire
Benjamin R. Matthews, Esquire
3400 Maxcy Street
Columbia, SC 29203
803.799.1700
tmegna@gmail.com

January 27, 2011.

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF DARLINGTON)

Pee Dee Health Care, P.A.,)

Plaintiff,)

v.)

Estate of Hugh S. Thompson, M.D.)

Case No. 10-CP-16-0332

Defendants.)
_____)

CERTIFICATION OF SERVICE

The undersigned hereby certifies that on the indicated below, a copy of the Plaintiff's Notice of Deposition upon the Defendant by delivering a copy first class mail, postage prepaid to

Jay James, Esquire
PO Box 507
Darlington, SC 29540

Renee Josey
1831 W. Evan Street
Florence, SC 29501

s/ Tony R. Megna

Tony R. Megna, Esquire
3400 Maxcy Street
Columbia, SC 29203
803.799.1700
tmegna@gmail.com

January 27, 2011.

TURNER PADGET

TURNER PADGET GRAHAM & LANEY P.A.

CHARLESTON
COLUMBIA
FLORENCE
GREENVILLE
MYRTLE BEACH

July 15, 2011

Christina Stewart
Email: CStewart@TurnerPadget.com
Writer's Direct Dial: (843) 656-4426

Ms. Kim Weatherford
Pee Dee Health Care, P.A.
201 Cashua Street
Darlington, SC 29532

RE: Claimant: Tanya S. Langston
 Employer: Pee Dee Health Care, P.A.
 Carrier: Companion Property & Casualty Group
 Claim No.: 5000892
 WCC File No.: 0320562
 Our File No.: 00576.00798
 D/A:

Dear Ms. Weatherford:

As your file should reflect, this firm represents Pee Dee Health Care, P.A., and their carrier in the workers' compensation claim referenced above. Please find enclosed a copy of the Hearing Notice regarding this matter. The Hearing is set for September 1, 2011, at 10:45 a.m., at the South Carolina Worker's Compensation Commission, 1333 Main St., Suite 500, Hearing Room B, Columbia, SC.

Please immediately provide us with the names of anyone who may attend on behalf of the Employer. J. Brandon Hylton, the attorney handling this case, will meet any witnesses outside of the courthouse approximately 30 minutes prior to the Hearing. He will need the personnel file and payroll records of Tanya S. Langston to be available for witness use only at that time. Please call us if you have any questions.

J. Brandon Hylton, the attorney handling this case, or I will be in touch with you in the near future to discuss this matter. In the meantime, if you should have any questions, please feel free to contact us.

Please contact us one (1) day prior to the hearing date to verify that there have been no changes to the hearing time, date or location.

BUSINESS • LITIGATION • SOLUTIONS

BB&T Building • 4th Floor • 1831 West Evans Street (29501) • PO Box 5478 • Florence, SC 29502 TPGL 3923940v1
Phone (843) 662-9008 • Fax (843) 667-0828 • turnerpadget.com

TURNER PADGET

Re: Tanya S. Langston
July 15, 2011
Page 2

Very truly yours,

TURNER PADGET GRAHAM & LANEY P.A.

A handwritten signature in cursive script, appearing to read "Christina Stewart".

Christina Stewart,
Paralegal to J. Brandon Hylton

/cbs
Enclosure (1) Hearing Notice
cc: Felicia Lucas (w/enclosure)

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #: 0320562
Carrier File #: 000005000892
July 14, 2011

NOTICE OF HEARING

TANYA S LANGSTON v. PEE DEE MEDICAL GROUP PA DBA

Subject: To determine issues as set forth on Forms 50 and 51.
Date: September 1, 2011 at 10:45 AM
Location: SC Workers' Compensation Commission, 1333 Main Street, Suite 500 Hearing Room B
Columbia, SC 29202

South Carolina Regulations 67-601 through 67-615 govern hearings before the South Carolina Workers' Compensation Commission. The claimant must attend when not represented by an attorney or when disfigurement is involved. Corporations must be represented by an attorney, and uninsured employers must attend.

Attorneys must file a Form 58 with proof of service pursuant to Regulation 67-611. Postponements are only granted pursuant to Regulation 67-613. Please visit www.wcc.sc.gov/Commissioners to view Commissioners' Preferences. If you have questions regarding this matter, please contact the office of the undersigned Jurisdictional Commissioner.

Commissioner T. Scott Beck
803-737-5698, abracy@wcc.sc.gov

CERTIFICATE OF SERVICE – This is to certify the undersigned has served this notice in the above entitled action upon all parties to this cause by sending a copy hereof by electronic mail or United States mail.

By: Amy A Bracy, SC Workers' Compensation, July 14, 2011

Party

Employee: TANYA S LANGSTON

Employer: PEE DEE MEDICAL GROUP PA DBA
Carrier: Companion Property & Casualty Ins. Co.

Attorney

William L. Smith II (2)
bsmith@csa-law.com
803-929-3600

J. Brandon Hylton
brandonhylton-group@turnerpadget.com
843-656-4460

CS

PEE DEE HEALTH CARE, P.A.

3400 WEST AVENUE
COLUMBIA, SOUTH CAROLINA 29203
803.254.3676

July 20, 2011

J. Brandon Hylton
Turner Padget Graham and Laney, P.A.
PO Box 5478
Florence, SC 29502

Sent via email to C. Stewart@turnerpadget.com, brandonhylton-group@turnerpadget.com, and bhylton@turnerpadget.com.

Re: Tanya S. Langston
Employer: Pee Dee Health Care, P.A.
Claim No: 5000892
WCC File: 0320562
Your file no: 00576.00798

Dear Mr. Hylton:

I am General Counsel to Pee Dee Health Care, P.A. We are in receipt of the attached letter dated July 15, 2011 and received by me on Monday, July 19, 2011. In regard to the matter, I would appreciate you taking the following actions:

1. Please address all further correspondence to me at 3400 West Avenue, Columbia, SC 29203. I am often out of the office, and would appreciate you also emailing all correspondence to tmegna@gmail.com.
2. Please provide me a hard-copy of your entire file, including but not limited to all billing statements, all correspondence, all documents obtained during discovery, copies of depositions, if any, and all other records pertaining to the file, however defined. Please also include all notes, documents and records [formal and informal notes and interoffice memos, if any, including but not limited to emails and/or other electronic communications, however defined] of all attorneys and staff employed by or contracted with your office who have had access to or worked on the file or whom you or others who have had access to or worked on the file, including informal discussions. If you decide not to disclose any document(s), material, records, or notes of conversations or discussions with anyone, please provide a description of the document(s) or matter(s) and the reason(s) you have decided not to provide the document or the information.
3. Please provide me a hard-copy of the entire file maintained at the Worker's

J. Brandon Hylton
July 20, 2011
Page 2 of 2

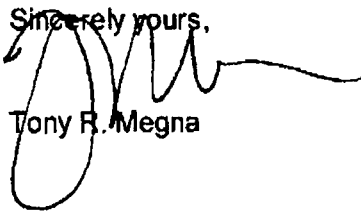
Compensation Commission, including but not limited all billing statements, all correspondence, and all records, however defined. If you decide not to disclose any document or material to me, please provide a description of the document and the reason(s) you have decided not to provide the document or the information.

4. Please provide me with a concise written statement of the outstanding issues in the case, your assessment of the case and any demands made by the claimant. Also, please let me know the exact nature of the upcoming hearing and the exact nature of the issues you expect to encounter.

In addition to providing hard copies of the foregoing I would appreciate you either emailing all the documents in a pdf format or providing them to me on a CD if the email attachment is too large to send. Thank you in advance for your consideration in these matters. As the hearing is scheduled for September 1, 2011, time is of the essence and I would therefore appreciate you providing me the foregoing information promptly.

Thanking you in advance for giving this matter your immediate attention, I remain,

Sincerely yours,



Tony R. Megna

July 25, 2011

J. Brandon Hylton
Email: BHylton@TurnerPadget.com
Writer's Direct Dial: (843) 656-4460

VIA HAND DELIVERY

Pee Dee Health Care, P.A.
Attn: Tony Megna, Esquire
3400 West Avenue
Columbia, SC 29203

RE: Claimant: Tanya S. Langston
 Employer: Pee Dee Health Care, P.A.
 Carrier: Companion Property & Casualty Group
 Claim No.: 5000892
 WCC File No.: 0320562
 Our File No.: 00576.00798
 D/A:

Dear Mr. Megna:

I am writing in response your letter dated July 20, 2011. Per your request, I have enclosed an cd containing my file.

As to the underlying issues, compensability and permanent disability have been resolved by a prior Order of the South Carolina Workers' Compensation Commission. The outstanding issues in this claim are future causally related medical treatment and whether Companion is responsible for past prescriptions and mileage related to Claimant's treatment with Dr. Stephens.

With regard to future medical treatment, the parties have attempted to reach an agreement to close out future medical treatment; however, all efforts have failed. Thus, Companion will continue to pay for Claimant causally related medical treatment. The last demand from the Claimant was \$350,000, plus professional administration of a Medicare Set-Aside Account. Companion's last offer was \$250,000.

With regard to past prescriptions and mileage, Claimant's attorney has requested reimbursement/payment for prescriptions written by Dr. Stephens in the amount of \$3,254.52 and mileage to/from the pharmacy to fill such prescriptions for a total of 912 miles. The adjuster, Felicia Lucas, is refusing to pay for the prescriptions and mileage until she receives Dr. Stephens' written medical records showing such prescriptions are causally related to the workers compensation accident.

TURNER PADGET

Re: Tanya S. Langston

July 25, 2011

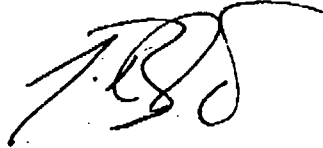
Page 2

As you know, I am in the process of withdrawing from representation of Pee Dee Health Care in this matter. The adjuster has requested that I send the file to Anne Noonan with Wilson, Jones, Carter, and Baxley.

With kind regards, I am

Very truly yours,

TURNER PADGET GRAHAM & LANEY P.A.

A handwritten signature in black ink, appearing to read 'J. B. Hylton', with a stylized flourish at the end.

J. Brandon Hylton, Esq.

JBH/jbh

Enclosure: CD of file

cc: Felicia Lucas

Matthews and Megna, LLC

Attorneys and Counselors at Law

3400 West Avenue

Columbia, SC 29203

TELEPHONE: 803-799-1700

E-mail: tmegna@gmail.com

FILED

2011 AUG 11 PM 4:00

SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

July 25, 2011

The Honorable J. Michael Baxley

531 East Carolina Avenue

Hartsville, SC 29550-4311

[Via email to JBaxleyLC@sccourts.org and first class mail]

Re: Estate of Hugh S. Thompson, Case No: 10-CP-16-0332

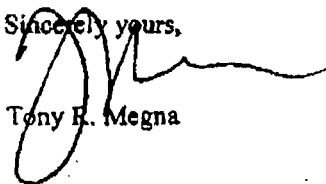
Dear Judge Baxley:

As discussed at the recent hearing before you on July 19, 2011, the Plaintiff has verified that Mr. Josey's law firm, in fact, currently represents Pee Dee Health Care, P.A. in a litigation matter that has been on-going for some time. Mr. Josey's representations to the Court at oral arguments were inaccurate. Please see the attached letters to Mr. Josey as well as the attorney in his law firm [Mr. B. Hylton] representing Plaintiff in the on-going litigation. Inexplicably, the Plaintiff has received no response from Mr. Josey, Mr. Hylton, Mr. James, nor anyone else as to the issues raised. See Rule 407, Rule 1.4.

Under the circumstances, the Plaintiff cannot consent to dual representation and respectfully requests that the Court strike all pleadings, correspondence, and arguments, however defined and provided to the Court, by Mr. Josey. The Plaintiff further requests the Court not consider any of the information or documents provided by Mr. Josey or his law firm in the case at bar. The Plaintiff makes its request pursuant to Rule 407, Rule 1.7, SCACR as well as Rule 1.16. "When a conflict arises after representation has been undertaken, the lawyer ordinarily must withdraw from the representation, unless the lawyer has obtained the informed consent of the client under the conditions of paragraph (b)." The immediate difficulty is that Mr. Josey's law firm has neither communicated nor withdrawn from representation of the Defendant in the case at bar. Once the actual facts, and their ramifications are known, the Plaintiff will advise the Court.

The Plaintiff reserves its right to take further actions following a determination of the effect of the dual representation. Thank you in advance for your consideration in this matter.

Sincerely yours,



Tony R. Megna

The Honorable J. Michael Buxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 25, 2011
Page 2 of 2

Cc:

Jay James
P.O. Box 507
Darlington, SC 29540
[Via email to
pilaw507@bellsouth.net and
first class mail]

Renee Josey
1831 W. Evans Street
Florence, SC 29501
[Via email to
RJosey@turnerpadget.com
and first class mail]

The Honorable Scott B. Suggs
Clerk Of Court,
Darlington County
1 Public Square, Room B-4
Darlington, South Carolina 29532
[hand-delivered]

Attachments:

Letter to Renee Josey via email dated July 20, 2011
Letter to B. Hylton via email dated July 20, 2011
Letter to Jay James via email dated July 20, 2011



FILED

Tony R. Megna <tmegna@gmail.com>

2011 AUG 11 PM 4:00
SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

PDHC v Estate of Thompson

1 message

Tony R. Megna <tmegna@gmail.com> Tue, Jul 26, 2011 at 2:39 PM

To: "Josey, J. Rene" <RJosey@turnerpadget.com>, pjlaw507

<pjlaw507@bellsouth.net>

Cc: bhyllon@turnerpadget.com, CStewart@turnerpadget.com, brandonhyllon-group@turnerpadget.com

Bcc: Joe Matthews <rurumatthews@yahoo.com>, Alex Cohen

<AHCOHENMD@aol.com>, Katie Noyes <katie@genesishqhc.org>, Mark

Matthews <nebendermm@yahoo.com>

Renee-

I have information that both you and Jay James have had extensive and multiple conversations with Douglas Truslow over the past several months. Based on the information in my possession, the contacts by both you and Jay with Mr. Truslow were adverse to the interests of PDHC - and extremely inappropriate under the circumstances as the contacts occurred during the same time period your law firm was representing Pee Dee Health Care.

At the point, you and Jay are likely witnesses, if not possible Defendants, in the Lake City litigation for multiple reasons including but not limited to aiding and abetting and breach of fiduciary duties to an existing client. For personal reasons, Drs. Matthews and Cohen have requested you and Jay be allowed the opportunity to withdraw voluntarily from representation of the Thompson matter prior to me requesting the Court to intervene and direct your collective disqualification. For differing personal reasons, I agree with their request. This is not intended as a release of liability of any kind for any reason. It is only a suggestion, and a means of allowing matters to settle out prior to further action(s) being considered.

I am out of town and, beginning tomorrow, I will be on vacation for the

rest of this week and next week. Unless I hear from you and Jay that you are withdrawing from the Thompson estate litigation, I will write Judge Baxley tomorrow morning and include the foregoing information with the request your firm be disqualified in the Thompson estate litigation. I will also request the Court take both retroactive and prospective action to protect and preserve the legal interests of PDHC in all matters - particularly as PDHC was a client to your law firm long prior to the Thompson estate. In this regard, I request once again that you rectify the inaccurate statements made you made on the record at oral arguments on July 19, 2011 in which you stated your firm did not represent PDHC.

As to Mr. Hylton, it appears you have placed him in a untenable position. His unilateral decision to withdraw from the litigation on behalf of PDHC, and throw aside ethical and legal considerations, is in direct conflict with his legal and ethical obligations to PDHC in that litigation as well as in all other matters that adversely or may adversely effect the interests of PDHC. Moreover, his complete failure to consult and communicate with me in light of my specific request to do so prior to taking such actions is astounding.

Tony R. Megna

Please send all written correspondence to:

Tony R. Megna, Esquire
3400 West Avenue
Columbia, SC 29203
tmegna@gmail.com
Office telephone: 803.799.1700

This message is intended for the use of the person or entity to which it is addressed and may contain information, including legal and/or health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you

have received this in error, please notify us immediately and destroy the related message. Thank you.

[REDACTED]

E-mail: tmegna@gmail.com

The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
[Via email to JBaxleyLC@sccourts.org and first class mail]

Dear Judge Baxley:

In addition to the above, I have been provided information that both Mr. Josey and Mr. James have had multiple conversations and conferences with at least one, if not several attorneys, involved with parties whose interests are adverse to the Plaintiff. As evidenced by the actual time and billing records in the possession of the Plaintiff [see below], these communications occurred during the same time period Turner Padgett has been representing Pee Dee Health Care. These communications concern matters involved in the 'Lake City litigation' to which the Plaintiff has previously referred the Court, and to other matters involving the undersigned. Counsel for the Defendant has made assertions before this Court that maintaining the Lake City litigation is not a factor in the current matter. The assertions appear incorrect based on the very limited information available to the Plaintiff. The following excerpts are copies of accounting and billing entries of an attorney who has had significant contact with the McNair Law Firm [a Defendant in the Lake City litigation] as well as significant contact with Mr. James and

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The Honorable J. Michael Baxley
 531 East Carolina Avenue
 Hartsville, SC 29550-4311
 July 27, 2011
 Page 2 of 4

Josey – all in matters directly adverse to the legal interests of the Plaintiff. The information in our possession is limited to time and billing statements which end on May 1, 2011.

May-22-08	Telephone conference(s) with McNair Law Firm re: files, status on Appeal and legal issue	1.00	295.00	DNT
Feb-04-11	Various work and conferences with J. James and R. Josey and follow up regarding comparison cases and ethics issues	4.00	1,180.00	DNT
Mar-07-11	Revision of Motion and research	2.00	590.00	DNT
	Telephone conference with J.J. and follow up	0.50	147.50	DNT
Mar-14-11	Telephone conference with J.J.	0.30	88.50	DNT
	Correspondence to Megna	0.10	7.50	ADH
Mar-15-11	Prepare letter; conference with J.J.; research issues (multiple) and follow up	2.00	590.00	DNT
Mar-28-11	Telephone call with J.J. and follow up	0.25	73.75	DNT
	Review of letters, memos and materials from Atty. Megna	0.75	221.25	DNT
	Correspondence to court	0.10	7.50	ADH
Apr-05-11	Telephone call with James re appeal, status of case and follow up	0.75	221.25	DNT

I have previously requested Mr. Josey and Mr. James withdraw from the current litigation due to the ethical and legal issues involved. Copies of the correspondence are included in the email with this letter to the Court. At this point, both Mr. James as well as Mr. Josey are likely necessary witnesses, if not Defendants, in adverse litigation that involves the Plaintiff as well as the principals of the Plaintiff, its' employees, and others. While we cannot be certain as to their

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 U.S. DISTRICT COURT
 DISTRICT OF SOUTH CAROLINA
 HARTSVILLE

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The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 27, 2011
Page 3 of 4

exact involvement in the matters at this time, the foregoing clearly evidence silent¹ involvement in matters not countenanced by PDHC or the undersigned.

I am on vacation for the rest of this week and next week. I respectfully request the Court review this information, and delay any further actions on the case at bar until I return. Upon return, I will file a formal motion requesting the disqualification of both Mr. Josey and Mr. James. The additional time will also allow time for the attached subpoenas to be responded to by Mr. James, Mr. Josey and others so that the parties and this Court will have the benefit of more information on which to base decisions. I request the Court accept this letter as an informal request to disqualify Mr. Josey and Mr. James from representing the Defendant. I will have the letter filed with the Clerk of Court this week. I make this request as attorney for the Plaintiff based on this Court's decision at the July 19th oral arguments staying it's previous order as it pertained to my continuing representation of PDHC. I previously notified both Mr. James and Mr. Josey of the requests PDHC is making of the Court, and requested their voluntary withdrawal. Neither has responded to any of the Plaintiff's attempts to keep these issues from escalating, other than the letter Mr. Josey provided to your office and the CD provided to my office. I have not had the opportunity to inspect the CD as I have been out of the office.

I respectfully request the Court take both retroactive and prospective action to protect and preserve the legal interests of PDHC in these matters as PDHC was a client to Turner Padgett prior to the Turner Padgett agreeing to the engagement of the Thompson estate. For unknown reasons, Mr. Josey nor Mr. James have chosen not to correct the inaccurate statements he made to you on the record at oral arguments of July 19, 2011 in which Mr. Josey stated his firm did not represent PDHC prior to its' representation of the Defendant. The statements were inaccurate as evidenced by the foregoing time and billing statements. Moreover, their silence concerning their knowledge of and involvement in the 'Lake City litigation' matters is of grave concern to the

¹ *Moore v. Moore*, 360 S.C. 241, 251, 599 S.E.2d 467, 472 (Ct.App.2004) ("Parties in a fiduciary relationship must fully disclose to each other all known information that is significant and material, and when this duty to disclose is triggered, silence may constitute fraud."); Conspiracy may be inferred from the very nature of the acts done, the relationship of the parties, the interests of the alleged conspirators, and other circumstances. *Island Car Wash, Inc. v. Norris*, 292 S.C. 595, 3538 S.E.2d 150 (Ct. App. 1987). "Civil conspiracy is an act which is by its very nature covert and clandestine and usually not susceptible of proof by direct evidence. . . ." *Id.* at 601, S.E.2d at 153. "It is axiomatic that a conspiracy may be proved by direct or circumstantial evidence or by circumstantial evidence alone." *Horne*, 324 S.C. at 381, S.E.2d at 294 (citing *State v. Childs*, 299 S.C. 471, 385 S.E.2d 839 (1989)). Indeed, *State v. Miller*, 223 S.C. 128, 74 S.E.2d 582 (1953), notes: "Often proof of conspiracy is necessarily by circumstantial evidence alone." *Id.* at 133, 74 S.E.2d at 585 (citation omitted).

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HARTSVILLE COUNTY, S.C.

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The Honorable J. Michael Baxley
531 East Carolina Avenue
Hartsville, SC 29550-4311
July 27, 2011
Page 4 of 4

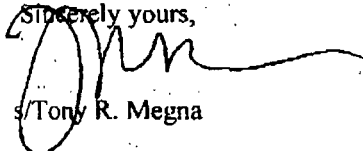
Plaintiff with far-reaching implications. I fail to understand how it is not reasonable to conclude their silence has been intended to misdirect or deceive both the Plaintiff and the Court.

These matters have developed very quickly and the Plaintiff has had very little time to evaluate and organize matters and documents to provide the Court a more complete picture of the extent of the legal and ethical concerns. However, the seriousness of the matter required your immediate notification. As noted above, and as attached hereto, I have subpoenaed records of parties which may bear upon the matters at bar. The subpoenas will be served in the next few days.

Concluding, the Plaintiff requests the Court not consider any of the information or documents provided by Mr. Josey or his law firm in the case at bar, and to stay all pending motions in order to allow sufficient time for these matters to be appropriately developed. Finally, the Plaintiff reserves its' right to take further actions following the determination of all foregoing matters.

Thanking you for your consideration, I remain

Sincerely yours,


s/Tony R. Megna

Cc:

Jay James
P.O. Box 507
Darlington, SC 29540
[Via email to
pilaw507@bellsouth.net

Renee Josey
1831 W. Evans Street
Florence, SC 29501
[Via email to
RJosey@turnerpadget.com]

The Honorable Scott B. Suggs
Clerk Of Court,
Darlington County
1 Public Square, Room B-4
Darlington, South Carolina 29532
[hand-delivered]

Attachments:

1. Subpoena directed to Renee Josey
2. Subpoena directed to Jay James
3. Subpoena directed to Desa Ballard
4. Subpoena directed to Kenneth Woodington
5. Subpoena directed to Brad Hylton
6. Subpoena directed to Celeste Jones

2011 JUL 28 AM 10:59
SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

FILED

Shm as to
all subpoenas
TV

TO: The named party on the attached subpoena

PLEASE BE ADVISED THAT the attached subpoena is intended to reasonable in scope and is not intended to place an undue burden upon you. In fact, it has but one request as noted below. The undersigned is open to any reasonable request you may have to minimize the burden or expense on you in responding to the subpoena. For instance, you may provide the documents in electronic format on a CD(s) in pdf format or by email in pdf format. In addition, you need not appear in person at the place of production or inspection as noted on the subpoena if you provide the documents prior to the date on the subpoena. If you cannot reasonably respond to the subpoena by August 17, 2011, please let me know, and we will make reasonable arrangements to accommodate your concerns.

In sum, all that is requested is that you provide the documents in your possession as noted on this request. The documents you provide will serve as your attestation that you have responded to the subpoena in good faith. If you have any reasonable request that will ease your burden or expense in responding to the subpoena, or any other question, please contact me by email at tmegna@gmail.com. You may also contact me directly by telephone at 803.606.5983. I will be out of the office for the next several days but will make every effort to respond to your concerns expeditiously.

Your cooperation is appreciated, and I look forward to hearing from you.

s/Tony R. Megna
Attorney at Law
3400 West Avenue
Columbia, SC 29203
Office: 803.254.3676 [please ask for Katie]

July 27, 2010.

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2011 JUL 28 AM 10:59
SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

EXHIBIT A TO SUBPOENA

TO: The named party on the attached subpoena

PLEASE BE ADVISED THAT the attached subpoena is intended to reasonable in scope and is not intended to place an undue burden upon you. In fact, it has but one request as noted below. The undersigned is open to any reasonable request you may have to minimize the burden or expense on you in responding to the subpoena. For instance, you may provide the documents in electronic format on a CD(s) in pdf format or by email in pdf format. In addition, you need not appear in person at the place of production or inspection as noted on the subpoena if you provide the documents prior to the date on the subpoena. If you cannot reasonably respond to the subpoena by August 17, 2011, please let me know, and we will make reasonable arrangements to accommodate your concerns.

In sum, all that is requested is that you provide the documents in your possession as noted on this request. The documents you provide will serve as your attestation that you have responded to the subpoena in good faith. If you have any reasonable request that will ease your burden or expense in responding to the subpoena, or any other question, please contact me by email at tmegna@gmail.com. You may also contact me directly by telephone at 803.606.5983. I will be out of the office for the next several days but will make every effort to respond to your concerns expeditiously.

Your cooperation is appreciated, and I look forward to hearing from you.

Pursuant to the SC Rules of Civil Procedure, Plaintiff hereby requests that the Defendants produce for inspection and copying the documents specified below at the office of the Attorney for the Plaintiffs, or by sending such documents to Tony R. Megna at 3400 West

ARLINGTON COUNTY, S.C.
CLERK OF COURT/R.O.D.
SCOTT B. SUGGS
JUL 28 AM 10:51

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Columbia, SC 29203, within 30 days from the date of service of this request, or by emailing the documents in pdf format to tmegna@gmail.com or by mailing the documents in pdf format on a CD(s). Please respond to the subpoena in the manner most convenient and cost effective for you.

DEFINITIONS

For purposes of this request for the subpoenaed production of documents, the following definitions apply:

- A. "Defendant" or "Defendants" and/or the "party named in this subpoena" refers to the party named in this subpoena and/or defendants named in this lawsuit, as well as any other person or entity in either of their agency or employ. This definition is intended to be construed broadly to include by any person who consults with, is employed by or has any other agency relationship, implied or express, with the Defendants and/or the party named in this subpoena.
- B. "Documents" includes records; books; papers; contracts; memoranda; invoices; correspondence; notes; minutes of any meetings, including meetings with agents or employees; instructions; guides; compilations of rules, regulations, or policies; daybooks; calendars; photographs; telegrams; messages; drawings; charts; graphs; other writings; recording tapes; recording discs; mechanical or electronic information storage or recording elements; and any other "documents" as that word is defined in Rule 34 of the Federal Rules of Civil Procedure, and in particular 'electronic evidence' including but not limited to e-mails, instant messages or other means of electronic communication. Please note that Rule 34, S.C.R.Civ.P., requires that the Defendants and/or the party named on the subpoena, as producing parties, are responsible for translating the information into a form readable to the Plaintiff, as the

discovering party. It is requested that electronic documents be provided in pdf format.

- C. "Relate" or "relating to" is defined as showing, reflecting, referring to, constituting, evidencing, or concerning in any way all or any portion of the subject matter of the facts, contentions, or matter.
- D. "Person" means any natural person, group of natural persons, corporation, partnership, government agency or board, association, proprietorship, organization, or any other legal entity.
- E. "Non-identical copies" means any copy of a document that is not identical to any other copy thereof, by reason of any alterations, marginal notes, comments, or other material contained thereon or attached thereto, or otherwise.
- F. A Document is defined to be synonymous in meaning and equal in scope to the usage of this term in Rule 34, S.C.R.Civ.P. A document specifically includes data compilations from which information can be obtained, translated, if necessary, by the party named in this subpoena through detection devices into reasonably usable form – regardless of where such data compilations located. A draft or nonidentical copy is a separate document within the meaning of this term.

INSTRUCTIONS

1. These requests apply to all documents in the possession, custody, or control of any party named in the attached subpoena regardless of their location and regardless of whether such documents are held by a defendant's agents, employees, representatives, attorneys, independent contractor's, paid consultants, unpaid consultants, or any other person.

2. These requests are continuing in nature. In the event the party named in this subpoena become aware of or acquire possession, custody, or control of additional responsive documents, the party named in this subpoena shall promptly produce such additional documents for inspection and copying.
3. All "non-identical copies" of every document whose production is sought shall be separately produced.
4. All documents produced in response to an individual request shall be physically segregated from documents produced in response to any other requests, and the request to which they are responsive shall be specifically identified. If a document is responsive to more than one request, each of the requests to which the document is responsive shall be specified.
5. In producing the documents, all documents which are physically attached to each other shall be left so attached. Documents which are segregated or separated from other documents, whether by inclusion in binders, files, sub-files, or by use of dividers, tabs, or other methods, shall be left so segregated or separated. Documents shall be retained in the order in which they were maintained in the file where found.
6. If an objection to a request is based upon a claim of privilege, attorney-work product, or any other basis, identify in writing each document so withheld by providing at least the following information:
 - a. the title and the subject matter of the document;
 - b. the title and the position of the sender of the document;
 - c. the identity and position of each person who participated in the preparation of the document or on whose behalf the document was prepared;

- d. the identity and position of all persons (1) to whom the document was addressed, (2) to whom the document was sent, (3) who have seen the document, (4) who have possession or custody of the document, and (5) who have had disclosed to them any of the contents of the documents; and
- e. a detailed statement of the basis for withholding the document, including facts establishing any claim of privilege, facts showing that the privilege has not been waived, and the status of the person claiming the privilege.
- f. Identify and produce all segregable portions of any responsive document to which a claim of privilege, attorney work product, or other basis for withholding the document does not apply.
- g. Identify all responsive documents that have been lost, discarded, or destroyed. In so doing, state the type of document, its date, the approximate date it was lost, discarded, or destroyed, and the identity of each person having knowledge of the contents thereof.

REQUESTS FOR PRODUCTION

1. Please identify all persons answering these requests for production. Please include a brief description of each person's involvement or status, if any, with the Defendants and/or the party named in this subpoena.
2. Please identify and produce, if any, all documents, including but not limited to emails, written communications, text messages, facsimiles, etc., and as defined hereinabove, that you obtained from or provided to the following individuals:
 - a. Douglas N. Truslow

- b. Desa Ballard
- c. Jay James
- d. J. Renee Josey
- e. Kenneth P. Woodington
- f. David Byrd
- g. Steve Licata
- h. Andy Savage
- i. Carolina Whitehead Streater
- j. Ashley Berry Stratton
- k. Pam Jolly
- l. Any and partners, associates, employees, or agents of the McNair Law Firm
- m. Any and partners, associates, employees, or agents of Law Firm of Turner Padgett
Graham and Laney, P.A.
- n. John Joseph McCauley
- o. Thomas George Earle
- p. Curtis W. Dowling

PLEASE BE ADVISED that the documents requested under the accompanying subpoena are limited to documents regarding (a) Pee Dee Health Care, P.A., (b) Tony R. Megna, (c) Benjamin R. Matthews, (d) Alexander H. Cohen, M.D., and/or (d) other persons known to you, upon reasonable investigation, to be employees of Pee Dee Health Care, P.A.

PLEASE BE FURTHER ADVISED that this request is limited to documents you obtained by you on or after January 1, 2008. To ease any burden and/or expense on you, please do not produce documents you have formerly produced and provided to the Plaintiff,

Pee Dee Health Care, P.A. Instead, please note and identify such documents and the date you formerly produced them.

Tony R. Megna
Attorney at Law
3400 West Avenue
Columbia, SC 29203
Office: 803.254.3676 [please ask for Katie]

July 27, 2010.

FILED
2011 JUL 28 AM 11:00
SCOTT B. SUGGS
CLERK OF COURT/R.D.D.
DARLINGTON COUNTY, S.C.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF DARLINGTON

PEE DEE HEALTH CARE, PA, Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON, Defendant

Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Celeste Jones

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY _____

COURTROOM _____

DATE AND TIME _____

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION _____

DATE AND TIME _____

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects:

See Exhibit A.

PLACE

201 Cashua Street, Darlington, SC 29532

DATE AND TIME Wed, August 17, 2011, @ 11:00 a.m.

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES _____

DATE AND TIME _____

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Tony R. Megna, Attorney for Plaintiff

July 27, 2011

Attorney/Issuing Officer's Signature

Date

Indicate if Attorney for Plaintiff or Defendant

Attorney's Address and Telephone Number:

3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]: telephone 803.626.5993

Clerk of Court/Issuing Officer's Signature

Date

Pro Se Litigant's Name, Address and Telephone Number:

FILED
2011 JUL 28 AM 11:00
CLERK OF COURT/ROD.
DARLINGTON COUNTY, S.C.

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS ☐ YES ☐ NO AMOUNT \$
	PLACE	
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

- i. fails to allow reasonable time for compliance; or
- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
- iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or
- iv. subjects a person to undue burden.

(B) If a subpoena:

- i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or
- ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or
- iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF RICHLAND

PEE DEE HEALTH CARE, PA, Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON, Defendant

Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Desa Ballard

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY _____	COURTROOM _____
_____	DATE AND TIME _____

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION _____	DATE AND TIME _____
---------------------------	---------------------

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects:

See Exhibit A.

PLACE <u>201 Cashua Street, Darlington, SC 29532</u>	DATE AND TIME <u>Wed, August 17, 2011 @ 11:00 a.m.</u>
---	--

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES _____	DATE AND TIME _____
----------------	---------------------

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Tony R. Megna, Attorney for Plaintiff

July 27, 2011

Attorney/Issuing Officer's Signature

Date

Print Name

Indicate if Attorney for Plaintiff or Defendant

Attorney's Address and Telephone Number:

3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]: telephone 803.606.5983

Clerk of Court/Issuing Officer's Signature

Date

Print Name

Pro Se Litigant's Name, Address and Telephone Number:

FILED
 2011 JUL 28 AM 11:00
 SCOTT B. SUGGS
 CLERK OF COURT/PRO.
 DARLINGTON COUNTY, S.C.

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS ☐ YES ☐ NO AMOUNT \$
	PLACE	
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

- i. fails to allow reasonable time for compliance; or
- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
- iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or
- iv. subjects a person to undue burden.

(B) If a subpoena:

- i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or
- ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or
- iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF DARLINGTON

PEE DEE HEALTH CARE, PA Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON Defendant

Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Jay James

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY _____	COURTROOM _____
_____	DATE AND TIME _____

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION _____	DATE AND TIME _____
_____	_____

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects:

See Exhibit A.

PLACE <u>201 Cashua Street, Darlington, SC 29532</u>	DATE AND TIME <u>Wed, August 17, 2011 @ 11:00 a.m.</u>
---	--

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES _____	DATE AND TIME _____
_____	_____

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(e)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES

Tony R. Megna, Attorney for Plaintiff

Attorney/Issuing Officer's Signature Indicate if Attorney for Plaintiff or Defendant Attorney's Address and Telephone Number: <u>3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]; telephone <u>803.606.5983</u></u>	Date _____	Print Name _____
---	------------	------------------

Clerk of Court/Issuing Officer's Signature Pro Se Litigant's Name, Address and Telephone Number _____	Date _____	Print Name _____
--	------------	------------------

FILED
 2011 JUL 28 AM 11:00
 SCOTT B. SUGGS
 CLERK OF COURT/PRO.
 DARLINGTON COUNTY, S.C.

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS
	PLACE	☐ YES ☐ NO AMOUNT \$
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

- i. fails to allow reasonable time for compliance; or
- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
- iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or
- iv. subjects a person to undue burden.

(B) If a subpoena:

- i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or
- ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or
- iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF DARLINGTON

PEE DEE HEALTH CARE, PA, Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON, Defendant

Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Brandon Hylton

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY

COURTROOM

DATE AND TIME

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION

DATE AND TIME

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects:

See Exhibit A.

PLACE

201 Cashua Street, Darlington, SC 29532

DATE AND TIME Wed, August 17, 2011, @ 11:00 a.m.

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES

DATE AND TIME

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Tony R. Megna, Attorney for Plaintiff

July 27, 2011

Attorney/Issuing Officer's Signature

Date

Print Name

Indicate if Attorney for Plaintiff or Defendant

Attorney's Address and Telephone Number

3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]; telephone 601.5983

Clerk of Court/Issuing Officer's Signature

Date

Print Name

Pro Se Litigant's Name, Address and Telephone Number

FILED
2011 JUL 28 AM 11:00
CLERK OF COURT PRO. D.
DARLINGTON COUNTY, S.C.

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS ☐ YES ☐ NO AMOUNT \$
	PLACE	
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

- i. fails to allow reasonable time for compliance; or
- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
- iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or
- iv. subjects a person to undue burden.

(B) If a subpoena:

- i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or
- ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or
- iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

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(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF DARLINGTON

PEE DEE HEALTH CARE, PA Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON Defendant

Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Renee Josey

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY _____	COURTROOM _____
_____	DATE AND TIME _____

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION _____	DATE AND TIME _____
---------------------------	---------------------

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects:

See Exhibit A.

PLACE <u>201 Cashua Street, Darlington, SC 29532</u>	DATE AND TIME <u>Wed, August 17, 2011</u> , @ <u>11:00 a.m.</u>
---	---

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES _____	DATE AND TIME _____
----------------	---------------------

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF. SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES

Tony R. Megna, Attorney for Plaintiff

Attorney/Issuing Officer's Signature

Date

Print Name

Indicate if Attorney for Plaintiff or Defendant

Attorney's Address and Telephone Number:

3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]; telephone: 803-605-5983

Clerk of Court/Issuing Officer's Signature

Date

Print

Pro Se Litigant's Name, Address and Telephone Number

FILED
2011 JUL 28 AM 11:00
CLERK OF COURT
DARLINGTON COUNTY, S.C.

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS
	PLACE	☐ YES ☐ NO AMOUNT \$
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

- i. fails to allow reasonable time for compliance; or
- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
- iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or
- iv. subjects a person to undue burden.

(B) If a subpoena:

- i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or
- ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or
- iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties In Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA

ISSUED BY THE CIRCUIT COURT IN THE COUNTY OF RICHLAND

PEE DEE HEALTH CARE, PA, Plaintiff

v.

SUBPOENA IN A CIVIL CASE

ESTATE OF HUGH S. THOMPSON, Defendant Case Number: 10-cp-16-0332

Pending in DARLINGTON County

TO: Kenneth Woodington

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY _____	COURTROOM _____
_____	DATE AND TIME _____

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Tony R. Megna, Attorney for Plaintiff

July 27, 2011

Attorney/Issuing Officer's Signature
Indicate if Attorney for Plaintiff or Defendant
Attorney's Address and Telephone Number:

Date

Print Name

2011 JUL 28 AM 11:00
FILED
SCOTT B. SUGGS
CLERK OF COURT
RICHLAND COUNTY, S.C.

3400 West Avenue, Columbia, SC 29203 [email: tmegna@gmail.com]: telephone: 606-5983

Clerk of Court/Issuing Officer's Signature
Pro Se Litigant's Name, Address and Telephone Number:

Date

Print Name

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS
	PLACE	☐ YES ☐ NO AMOUNT \$
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____

SIGNATURE OF SERVER

ADDRESS OF SERVER

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- ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or
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WILLSON JONES CARTER & BAXLEY, P.A.

ATTORNEYS AT LAW

GREENVILLE CHARLESTON COLUMBIA CHARLOTTE RALEIGH

Anne Veatch Noonan
Direct (843) 284-1097
Fax (843) 284-1081
avnoonan@wjclaw.net

421 Wende Park Boulevard, Suite 100
Mount Pleasant, SC 29464
www.wjclaw.net

August 3, 2011

Ms. Virginia Crocker
South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Re: Tanya Langston vs. Pee Dee Healthcare, PA
WCC File No.: 0320562 DOI: 11/3/2003
Carrier: Companion Property & Casualty Company - Claim No.: 000005000892
WJC&B File No.: 0230.00613

Dear Ms. Crocker:

Enclosed please find an original and two copies of a proposed Consent Order for Substitution of Counsel in the above-referenced matter. Please process the Consent Order through the Commission and return a date-stamped filed copy to all parties in the envelopes provided.

Thank you for your attention to this matter, and please do not hesitate to contact me if you have any questions or concerns.

With kindest regards,

WILLSON JONES CARTER & BAXLEY, P.A.



Anne Veatch Noonan

AVN/Ins
Enclosures

cc (w/enclosures): J. Brandon Hylton, Esquire
William L. Smith, II, Esquire
Ms. Felicia Lucas
Ms. Kim Weatherford
Tony Megna, Esquire

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0504802

Tanya S. Langston,

Employee,

Claimant,

vs.

Pee Dee Health Care, P.A.,

Employer,

AND

Companion Property & Casualty Group,

Carrier,

Defendants.

**CONSENT ORDER FOR
SUBSTITUTION OF COUNSEL**

The undersigned hereby consents to substitute Anne V. Noonan, Esquire, Willson Jones Carter & Baxley, P.A., as counsel for the Defendants Pee Dee Health Care, P.A. and Companion Property & Casualty Group in the above-referenced matter. J. Brandon Hylton is to be relieved as counsel. The substitution of counsel will neither prejudice the parties nor cause undue delay in the disposition of this matter.

IT IS THEREFORE ORDERED that Anne V. Noonan, Esquire, Willson Jones Carter & Baxley, P.A., be substituted for and as counsel for Defendants Pee Dee Health Care, P.A. and Companion Property & Casualty Group in the above matter. J. Brandon Hylton has no further obligation to represent the Defendants herein.

IT IS SO ORDERED.

[Signature page follows]

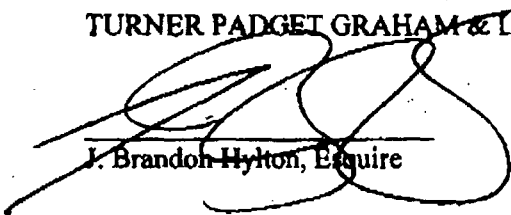
**SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION**

BY: _____
Commissioner

August _____, 2011
Columbia, South Carolina

WE CONSENT:

TURNER PADGET GRAHAM & LANEY, PA



J. Brandon Hyton, Esquire

WILLSON JONES CARTER & BAXLEY, P.A.



Anne V. Noonan, Esquire

TPGL 3952324v1



State of South Carolina
The Circuit Court of the Fourth Judicial Circuit

J. MICHAEL
BAXLEY
JUDGE

531 EAST CAROLINA AVENUE
HARTSVILLE, SOUTH CAROLINA 29550
TELEPHONE: (843) 383-4114
FAX: (843) 383-4118
E-MAIL: jbaxley@sccourts.org

August 12, 2011

John Jay James, II, Esquire
Pauling & James
Post Office Box 507
Darlington, SC 29540

J. Rene Josey, Esquire
Turner, Padgett, Graham & Laney
Post Office Box 5478
Florence, SC 29502

Benjamin R. Matthews, Esquire
Matthews & Megna
3400 West Avenue
Columbia, SC 29203

Re: Pee Dee Health Care, PA v. Estate of Hugh S. Thompson
Case Number: 2010-CP-16-0332

Gentlemen:

Thank you for your patience while the cross motions for summary judgment have been under advisement in this case. I have now had the opportunity to further review this matter, applicable statutes, prevailing case law, the extensive memoranda and exhibits, and further consider the arguments of counsel. Please accept this letter as notice of the Court's decision.

The Plaintiff's motion for summary judgment is denied, while that of the Defendant is granted. The basis for this decision is that the Court finds, as a matter of law and fact, that the Plaintiff cannot prove an absence of fault in causing the existence of the underlying debt being sued upon, and is collaterally estopped from asserting such a position. In spite of the fact that Plaintiff has asserted multiple causes of action in its complaint, all claims derive from a core set of facts that have already been adjudicated with finality against Plaintiff by federal administrative decisions.

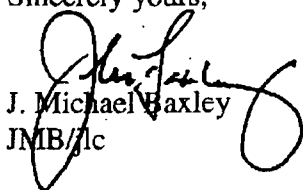
Over and above the federal decisions, the established facts of this case do not permit recovery by the Plaintiff under South Carolina substantive law. In reaching this decision, the Court is persuaded by the words of Judge Ralph K. Anderson in *Regions Bank v. Schmauch*, 582 SE 2d 432 (Ct. App. 2003), "One with knowledge of the truth or the means by which with reasonable diligence he could acquire knowledge cannot claim to be misled." This is particularly true where the claim comes years later after the fact as a mere bystander and party to the events in question.

Scott D. Suggs
TRUE CERTIFIED COPY

Attorney James is requested to prepare an Order within ten (10) days of the date of this letter detailing the decision stated herein and forward the same to opposing counsel. Attorney Matthews is not asked to agree or consent to the Order, but is requested to review it for mistake of fact or misstatement of your party's position; thereafter, Attorney James is asked to forward the finalized Order to the Court. Attorney James is requested to send an electronic copy in Word format via email (jbaxleylc@sccourts.org) to my office for signature, which will then be finalized, signed, and returned to Attorney James for filing and formal service on the parties.

I have enjoyed working with you in this matter, and look forward to the time when we shall have the opportunity to work together again.

Sincerely yours,


J. Michael Baxley
JMB/jc

cc: Honorable Scott B. Suggs (for filing) ✓

FILED
2011 AUG 15 AM 10:41
SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.



The South Carolina Court of Appeals

TANYA A. GEE
CLERK

V. CLAIRE ALLEN
DEPUTY CLERK

POST OFFICE BOX 11629
COLUMBIA, SOUTH CAROLINA 29211
1015 SUMNER STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE: (803) 734-1890
FAX: (803) 734-1839
www.sccourts.org

December 7, 2011

Renee Josey, Esquire
Turner, Padgett, Graham
& Laney, P.A.
P O Box 5478
Florence, SC 29502

Re: Pee Dee Health v. Thompson, Hugh
Case #2011185767

Dear Counsel:

We have received the Motion to Dismiss in the case of Pee Dee Health v. Thompson, Hugh. Please be advised that the appellant has filed three similarly titled appeals with this Court to appeal three separate orders.

The first appeal was filed in this Court on February 16, 2011 under the lower court case number of 2010-CP-16-00633 dated January 17, 2011, and given the case tracking number of **2011185767**. The second appeal was filed in this Court on August 24, 2011 under the lower court case number of 2010-CP-16-00332 dated August 12, 2011, and given the case tracking number of **2011197671**. And the third appeal was filed in this Court on November 07, 2011 under the lower court case number of 2010-CP-16-00332 dated August 29, 2011, and given the case tracking number of **2011203391**.

The Motion to Dismiss Appeal on Merits as Untimely and Dismiss all Interlocutory Appeals as Moot is currently pending under Case #**2011203391**. If you wish for this Motion to be considered for all three appeals, it will be necessary to file a separate Motion for each of the remaining two pending appeals.

Very truly yours,

V. Claire Allen, Deputy
CLERK

TAG/jt

cc: Tony Ray Megna, Esquire
Jay James, Esquire

REASSIGNMENT APPLICATION MEDICARE PROVIDER CERTIFICATION

98324 THIS APPLICATION IS TO BE COMPLETED FOR ANY INDIVIDUAL WHO WILL REASSIGN HIS OR HER BENEFITS TO AN ELIGIBLE ENTITY. 98324900647

Check box indicating the reason this application is being completed.
(Note: definitions of the following terms are found in the instructions.)

- ☐ Initial Enrollment
☐ Deleting a Reassignment
☐ Changing State of an Individual
☒ Adding a Reassignment
☐ Changing Status of an Individual

RECEIVED

NOV 10 1998

Legal Business Name <i>Pee Dee Health Care, Inc.</i>		MEDICARE PROVIDER CERTIFICATION	
"Doing Business As" Name <i>SAME</i>		MEDICARE PROVIDER CERTIFICATION	
Entity Employer Identification Number <i>570638347</i>		Entity Medicare Identification Number <i>1724</i>	

Adding or Listing Individual ☒		Date Individual Reassigned Benefits (required) <i>10/26/1998</i>	
Deleting Individual ☐		Date Individual Terminated Reassignment (if applicable) <i>(RANDOMYY)</i>	
Name First <i>Hugh</i>	Middle <i>S</i>	Last <i>Thompson</i>	Jr., Sr., etc. <i>MD</i>
Social Security Number <i>251-62-3993</i>		Medicare Identification Number <i>D99321</i>	Date of Birth <i>02/10/40</i>
Individual Primary Specialty <i>Anesthesiology</i>		Individual Secondary Specialty (optional) <i>NA</i>	
What income reporting form does the individual receive from the entity or the Internal Revenue Service at the end of the calendar year? ☒ W-2 ☐ 1099 ☐ 1099-K1 ☐ Other			

At how many locations does this individual render services for the entity identified above?
List all locations where this individual will render services for this entity.

If additional space is needed, copy page, complete this section and attach to application.

Legal Business Name For This Location <i>Pee Dee Health Care, Inc.</i>		RECEIVED	
"Doing Business As" Name For This Location <i>SAME</i>		NOV 10 1998	
Business Street Address Line 1 <i>201 Carthage Street</i>		MEDICARE PROVIDER CERTIFICATION	
Business Street Address Line 2			
City <i>Darlington</i>	County <i>Darlington</i>	State <i>SC</i>	ZIP Code + 4 <i>29532</i>

Palmto Government Benefit Administrators
Med B - Document Control - Camden, SC

RECEIVED

SENT

08222

HCFA 0004 (1/88)

1

Billing Agency/Management Service Organization AddressCheck here ☒ only if this entire section does not apply to the applicant.

Complete this section if the entity is using a billing agency or management service organization.

Agency/Management Service Organization Name				Employer Identification Number	
Organization First		Middle	Last		Jr., Sr., etc.
Person Name					
Street Address Line 1					
Street Address Line 2					
State			ZIP Code + 4		
Phone Number		Fax Number		E-mail Address	

Reassignment of Benefits Statement

Health care law prohibits payment for services to entities other than the practitioner who provided the services unless the practitioner specifically authorizes another entity (employer, facility, health care delivery system, or agent) to receive payment for his or her services, per Federal Regulation 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the entity identified in Section 1 to receive Medicare payments on your behalf.

Your employment or contract with this entity must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all providers, suppliers, and individuals who allow an entity (employer, facility, health care delivery system, or agent) to receive payment for your services.

I acknowledge that, under the terms of my employment or contract, I am entitled to claim or receive any fees or charges for my services.

Pea Dee Health Care, PA
(Legal Business Name of Entity)

Signature		First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
		Hugh	S	Thompson		MD
Date (MM/DD/YYYY)						11/04/1998

Contact Person

Supply the name and telephone number of a person who can answer questions about the information furnished in this application.

First	Middle	Last	Jr., Sr., etc.	Telephone Number
ARACN	M	Matthews	SR	(843) 393-7452

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws. I certify that the entity applying to receive payments is eligible to receive reassigned benefits.

Representative Name		First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
JAMES			D	MCINNIS		MD
Representative Title/Position		Social Security Number		Medicare Identification Number (if applicable)		
President		248 508 911		B91882		
Date (MM/DD/YYYY)					11/16/98	

Medical University of South Carolina

*On the nomination of the Faculty
of the*

College of Medicine

has conferred upon

Hugh Smith Thompson, Jr.

the degree of

Doctor of Medicine

In testimony whereof this Diploma has been issued at Charleston

*in the State of South Carolina this seventeenth day of March in the year of our
Lord one thousand nine hundred and seventy-three.*

Harmon L. Phelps, M.D.
Chairman, Board of Trustees



William M. Bond
President
W. A. Williams
Dean, College of Medicine

Medical College of South Carolina

On the nomination of the Faculty
of the

School of Pharmacy

has conferred upon

Hugh Smith Thompson, Jr.

the degree of

Bachelor of Science in Pharmacy

In testimony whereof this Diploma has been issued at Charleston,
in the State of South Carolina, this first day of June
in the year of our Lord one thousand nine hundred and sixty-seven.

Edwin Schacht, Jr.

Chairman, Board of Trustees



William McKee Cord
President
William F. Cord

FOWLER RURAL MEDICAL CLINIC
DON H. FOWLER, M.D.
P.O. BOX 875 210 E. DOZIER ST.
MARION, S.C. 29571-0875
(843) 423-4044
FAX (843) 423-3489

June 30, 1998

Mr. Tom Fuller, Administrator
Marion County Medical Center
Marion, S.C. 29571

RE: Hugh Thompson, M.D.

Dear Tom:

Please find attached a letter from Hugh Thompson, M.D. explaining his current situation. Dr. Thompson began working at Fowler Rural Medical Clinic in May of this year. Our agreement is that he continue his CME in Family Practice and works in the clinic under my supervision until such time we both feel comfortable requesting hospital privileges.

I would like for him to perform History and Physicals and dictate Discharge Summaries in the near future. We have requested the approval of the Medical Board for these privileges and are awaiting their answer.

I will be happy to keep you abreast of any developments. As you know I desperately need this help and have been very pleased with his performance over the last six weeks. He is knowledgeable, personable and eager to learn more about the practice of Family Medicine.

I am asking for your patience in this matter and apologize for any confusion or inconvenience this may have caused.

Sincerely,

Don H. Fowler, M.D.

Don H. Fowler, M.D.

cc: Medical Staff

Duke University

Duke University Medical Center

this is to certify that

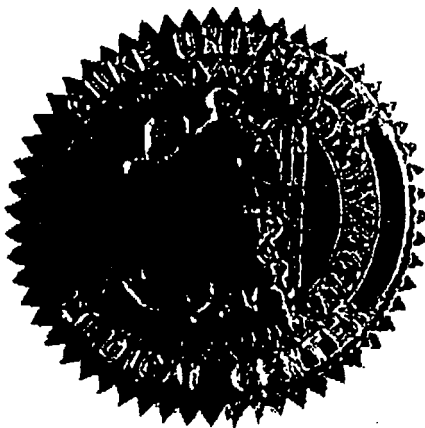
Hugh Smith Thompson, M.D.

*Has Completed Creditably Postgraduate Training
in the Duke University Medical Center
and Affiliated Hospitals*

**Department of Anesthesiology
Resident 10.1.74 ~ 9.30.76**

October 1, 1976

Durham, North Carolina



Eured W. Burse
Director, Medical Education

Stuart M. Jessome
Hospital Director

Merce H. Harwell
Chairman of Department

National Board of Medical Examiners

of the

United States of America

Hugh Smith Thompson, M.B.

*having satisfied all the requirements and having successfully
passed the examinations is hereby declared a*

Diplomate of the National Board of Medical Examiners

Attest

J. Myers

Chairman of the Board

John A. Hubbard

President of the Board

Philadelphia, Pa.

July 1, 1974



Certificate No. 120029

SC Department of Labor, Licensing and Regulation
Board of Medical Examiners
1999-2000

REGISTRATION
CERTIFICATE

PHYSICIAN

EXPIRES 12/31/2000



ALL PHYSICIANS LICENSED BY THIS BOARD ARE REQUIRED
TO REREGISTER ANNUALLY. APPLICATIONS ARE MAILED BY
MAY 1st EACH YEAR. THIS IS TO CERTIFY THAT THE PHYSICIAN
NAMED BELOW HAS REREGISTERED WITH THE BOARD.

DR. HUGH S. THOMPSON

CERTIFICATE &
LICENSE NUMBER
REPORT CHANGES
AS REQUIRED.

7087

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

P.O. Box 11389 • Columbia, SC 29211-1389

American Medical Association

Physicians dedicated to the health of America



July - December 1999

- ☐ Yes, I want to apply for my AMA membership and confirm my commitment to the Principles of Medical Ethics.
- ☐ Please send me state/county medical society membership information.

Hugh Thompson MD
115 N Ervin St
Darlington SC 29532

Half Year Membership Application

1999 Dues

210.00

(If payment has already been made, please disregard this section.)

- Payment method: ☐ Check made payable to AMA
- ☐ MasterCard ☐ VISA ☐ AMEX ☐ OPTIMA

Please check credit payment method below (select one option):

- ☐ Credit card single payment
- ☐ Credit card single payment with automatic renewal
- ☐ Credit card installment payment with automatic renewal
- ☐ Bill back for credit payment (signature required)
- ☐ Multi-Year Regular Physician Membership
- Pay for 4 years - (at the 5th year term) (Physicians Only)
- ☐ Yearly payments with automatic renewal
- ☐ Monthly payments with automatic renewal

Credit Card No

Signature Required

Signature Name

Exp. Date

04501731311 80 99 18102A 12610

Address Verification

To help ensure your benefits reach you in a timely fashion, please verify your address.

Hugh Thompson MD
04501731311

Please print clearly your corrected or preferred mailing address below.

Name

Address

City

State

Zip

Telephone

Fax

e-mail

Is this your: ☐ Home ☐ Office ☐ Other

Return this application in the enclosed postage-paid envelope or mail to:
Membership Processing, American Medical Association, P.O. Box 24842, Chicago, IL 60624-0842

Membership Qualification Questions

(Not applicable to medical students.)

Hugh Thompson MD
04501731311 80 99 18102A 12610
Darlington SC 29532

Members of the AMA abide by the Principles of Medical Ethics. To assist us in upholding these standards, please provide the answers to the following questions. Then sign and date this application and return it in the postage-paid envelope.

Yes/No

- ☐ ☐ 1. Have you been convicted of fraud or a felony within the last five years?
- ☐ ☐ 2. Has any action, in any jurisdiction, been taken regarding your license to practice medicine within the last five years or extending to within the last five years? This includes actions involving revocation, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license.

- ☐ ☐ 3. Have you been the subject of any disciplinary action by any medical society or hospital staff within the last five years?

If you answered yes to any of these questions, please attach full information. The foregoing information is true and complete, and I endorse the Principles of Medical Ethics (see back).

Signature

Date

Your AMA membership (except for fully retired members) includes benefits of membership subscription to *Journal of the American Medical Association* (JAMA) (12 issues per year) and *American Medical News* (12 issues per year). \$10.00 of standard dues are allocated for each publication. These subscriptions are a benefit of membership and are not deductible from the annual AMA membership fee. Allow 4-6 weeks to receive your first issue.

6/8/99

TO: Jean
FR: Mark

HUGH S. THOMPSON
111 N ERVIN ST
DARLINGTON, SC 29532

DATE 6/8/99 3347

PAY TO THE ORDER OF *Darlington Memorial Education Bd* \$ *175.00*

One hundred seventy five and 00/100 DOLLARS

DARLINGTON COUNTY BANK
DARLINGTON, SC 29532

1999 Algeria File CME

⑆053201896⑆ 0101555906 3347

CME 36 credit hours

Dr. Thompson

Prof. Dev.
DMC

Wm

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

In the Matter of:

Hugh S. Thompson, M.D.,

Licensee.

PRIVATE AGREEMENT

WHEREAS, Licensee has advised the Board of a commitment to a life of sobriety and willingness to submit at Licensee's expense to such tests and other conditions as the Board may desire, from time to time, to assure it of Licensee's continued compliance with that commitment.

THEREFORE, IT IS UNDERSTOOD AND AGREED THAT:

1. This Agreement is not a disciplinary action under S.C. Code Ann. §40-47-200 (Supp. 1996), but instead is a reasonable accommodation designed to protect the public and assist Licensee in a continuing recovery effort. Licensee hereby consents to the monitoring of Licensee's treatment and practice of medicine. Licensee specifically consents and does hereby agree to comply with the following terms and conditions, which shall continue in effect until further Order of the Board:

- (a) Licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. All use of such substances is to be reported by Licensee to the Board or its designee within 48 hours of initiation. All such medical treatment and prescribing shall be reported directly to the Board in writing by the treating practitioner within ten (10) days after the date of treatment. Licensee must inform the treating practitioner of this responsibility and ensure timely compliance. Failure to inform the treating practitioner of this responsibility shall be considered a violation of this Agreement.
- (b) Licensee shall be subject to periodic, unannounced blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the Licensee remains drug and/or alcohol-free. The cost of such blood and urine alcohol and/or drug analyses and reports will be borne by Licensee, which costs shall be paid within thirty (30) days after the date of the invoice therefor. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Agreement.
- (c) Licensee must have a written contract with and be an active participant in the activities of an aftercare program approved in advance in writing by the Board including, but not limited to, the Physicians Advocacy and Assistance Committee of the South Carolina Medical Association, or a successor program approved as such

by the Board (hereinafter the Program). Such contract shall specify the required frequency of attendance at support groups, or other such activities as the Program shall deem appropriate, including, but not limited to:

- (1) Monitoring and aftercare activities of the Program;
- (2) Alcoholics Anonymous (AA) or Narcotics Anonymous (NA);
- (3) Caduceus support groups or its equivalent approved by the Board;
- (4) Such additional therapeutic activities as deemed appropriate and necessary by the Program when incorporated into the contract.

Licensee shall submit or arrange for the submission of quarterly written reports documenting Licensee's regular participation in such therapeutic activities deemed appropriate by the Program, and documenting Licensee's full compliance with the terms of the contract with the Program and this Agreement. Said reports shall be submitted on or before the first day of April, and every third month thereafter.

- (d) Within thirty (30) days of the date of this Agreement, Licensee must provide to the Board a letter signed by an appropriate representative of the Program mentioned above verifying that Licensee has signed a written contract with and become an active participant in the activities of the Program, as required above. Compliance with this paragraph shall not be deemed satisfied until said written verification is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.
- (e) Licensee shall appear and report to the Board as requested by the Board.
- (f) Licensee shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Agreement. Correspondence and copies of reports and notices mentioned herein shall be directed to:

LLR-Board of Medical Examiners
P. O. Box 11289
Columbia, SC 29211-1289

2. It is understood and agreed that by executing this Agreement, Licensee specifically consents to execute and to deliver to the Board, within ten (10) days of request, an authorization for the release to the Board of any and all records, reports, or other information concerning Licensee by any and all persons or entities involved, notwithstanding any privilege provided by federal or state law. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

3. It is further understood and agreed that this Agreement is not to be considered a public document under the South Carolina Freedom of Information Act and shall remain private. However, a copy of this Agreement may be provided by the Board upon written request by any other federal or state licensing or regulatory authority.

4. It is further understood that, because of its private nature, this Agreement does not require Licensee to disclose its existence to others, except federal or state licensing or regulatory authorities.

5. It is further understood and agreed that each provision of this Agreement shall be subject to review by the Board. Licensee shall cooperate with the Board, its attorneys, investigators, and other representatives in the investigation of Licensee's practice and compliance with the provisions of this Agreement. Licensee may be required to furnish the Board with additional information as may be deemed necessary by the Board or its representatives. In addition to such requests, the Board in its discretion may require Licensee to submit further documentation regarding Licensee's practice, and it is Licensee's responsibility to fully comply with all such requests in a timely fashion. Failure to satisfactorily comply with such requests will be deemed a violation of this Agreement.

6. It is further understood and agreed that in the event that public action is subsequently taken by the Board as a result of violation of the terms and conditions provided herein, then this Agreement shall become disclosable as a public document under the South Carolina Freedom of Information Act.

7. It is further understood and agreed that if Physician fails to abide by any of the aforementioned terms and conditions, or if it should be indicated from reliable reports submitted to the Board that Physician is otherwise unable to practice medicine with reasonable skill and safety to patients, then Physician's license may be immediately temporarily suspended until further Order of the Board following hearing into the matter of the failure. It is understood and agreed that by executing this Agreement, Physician specifically consents to waive the procedural requirements of S.C. Code Ann. §40-47-200 and Regulation 81-12.5. It is understood and agreed that by executing this Agreement, Physician specifically consents to consideration by the Board of any appropriate sanction under §40-47-200 after the hearing required by this paragraph.

8. It is further understood and agreed that this Agreement does not satisfy, prejudice, or stay any disciplinary action currently pending before the Board or which may be filed in the future.

AND IT IS SO AGREED.

STATE BOARD OF MEDICAL EXAMINERS

Effective: _____
Date

BY: _____
BEN C. PENDARVIS, JR., M.D.
President of the Board

I AGREE:

LICENSEE

Date

WITNESS OR ATTORNEY

Date

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
Post Office Box 210738
Columbia, SC 29221-0738
(803) 731-1687

CERTIFICATE OF MEMBERSHIP

HUGO S. Thompson, M.D. SC 7087
NAME Fowler, Rural Medical Clinic MARION, SC. 29571 LICENSE NUMBER (843) 423-4044
210 E. Dozier St. WORK ADDRESS 111 W. Ervin St. - Dorlington, S.C. 29532 TELEPHONE (843) 393-3609
HOME ADDRESS TELEPHONE
J.U.A. So 60 Polkwood 5-18-98 - 5-18-99 100,000 / 300,000.
BASIC INSURANCE BASIC POLICY # BASIC POLICY DATES BASIC LIMITS
OCCURRENCE \$85600 -0- Family Practice
TYPE OF POLICY BASIC INS PREM PCF MEMBERSHIP FEE TYPE PRACTICE
Occurrence/Claims

I hereby agree to assist and cooperate with the PCF in all matters connected with my membership in the PCF.

I furthermore understand and agree that my membership in the PCF is contingent on my having in force basic malpractice insurance coverage with limits not less than \$100,000 per claim and \$300,000 annual aggregate for all claims, unless I have been certified by the PCF as a self-insured.

I furthermore understand and agree that my membership, along with all benefits provided to me by the PCF, will be suspended during the entire period of time that I do not have the required basic malpractice insurance coverage in force, unless I have been certified by the PCF as a self-insured.

I furthermore understand and agree that the PCF has no obligation and will make no payments for the defense or settlement of claims or judgments for incidents which occur during the suspension period.

WITNESS:

Ruth R. Brady
Notary Public

[Signature]
Member

(PCF Use Only)

The PCF membership of _____
is hereby certified for the period of _____ to _____. Said
membership is subject to the above conditions.

Date

Administrator

Please return this form to the above address, a copy will be sent to you after processing.

Medical University of South Carolina

Teaching Hospitals

Charleston, South Carolina

This is to Certify that

Arch Smith Thompson, M.D.

has completed the following training

SURGERY INTERN

for the period July 1, 1973-June 30, 1974

at these Hospitals and during such service has conducted himself creditably.

Dated at Charleston, South Carolina this at day of July , 1974

J. B. Williams
Dean, College of Medicine

W. F. Smith
Department Chairman



Be it known that

Hugh S. Thompson

has been elected to membership at

The Medical College of South Carolina

Anno Domini 1973

John Z. Bowers *President*
James A. Campbell *Secretary-Treasurer*

Fellow-in-Anesthesiology

THE AMERICAN



COLLEGE OF

ANESTHESIOLOGISTS

OF

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

This is to certify that

Hugh Smith Thompson, M.D.

a duly licensed Physician, having complied with all the requirements of

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS,

and having demonstrated to its satisfaction an adequate preparation and experience together with special knowledge of the art and science of Anesthesiology, and being proficient in the practice of this specialty is hereby admitted as a

Fellow of The American College of Anesthesiologists

BY EXAMINATION

John S. Halley M.D.
President, A.S.A.

Richard T. Ward M.D.

8283

Eugene C. Noyes M.D.

The American Board of Anesthesiology

Hereby certifies that

Hugh Smith Thompson

a licensed Graduate of Medicine, having complied with all the requirements of this Board, is qualified to serve as a consultant in Anesthesiology.

Given this third day of October, 1980



Robert L. Enrie, M.D.

President

Orel B Crawford M.D.

Vice-President

E. L. L. M.D.

Secretary-Treasurer



Certificate No. 9785

Fowler Rural Medical Clinic
Don H. Fowler, M.D.
P.O. Box 875
Marion, S.C. 29571-0875
(843)423-4044
FAX (843)423-3489

August 20, 1998

Mr. Aaron Kozloski, Executive Director
S.C. Board of Medical Examiners
P.O. Box 11289
Columbia, S.C. 29211-1289

Dear Mr. Kozloski:

I am writing to confirm to my satisfaction with the performance of Hugh S. Thompson, M.D. Doctor Thompson has, at my request, petitioned the Board to allow him to do histories, physical examinations and discharge summaries on the hospitalized patients of this clinic. Doctor Thompson has performed his duties in a prudent and professional manner. He has demonstrated basic clinical competence and continues in his enthusiasm to increase his knowledge and skills in Family Practice. He has shown good judgment in being prompt to request consultation in patient care problems with which he feels he needs the input of experience.

From the standpoints of hastening his integration into this practice, as an educational tool, and as a great help to this practice, I feel it is entirely appropriate for him to undertake these duties. I would very much appreciate the Board's granting him this request.

Sincerely,

Don H. Fowler, M.D.

CC: Hugh S. Thompson, M.D.



MEDICARE

Part A Intermediary
Part B Carrier
OME Regional Carrier

DATE: December 8, 1998

Hugh S. Thompson, M.D.
Pee Dee Health Care, Inc.
201 Cashua St.
Darlington, SC 29532

Dear Dr. Thompson:

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and or practitioner(s). The member(s) listed below have the participation status of the group practice. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Provider Name	Provider Number	Effective Date	Expiration Date
Hugh Thompson	D993211724	October 26, 1998	NA

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

If you are filing claims electronically please contact our Electronic Data Interchange (EDI) department at (803) 788-9751 to update your EDI Enrollment Form.

If we may be of further assistance please call our Medicare Part B Customer Service Center at (803) 788-5568. A customer service representative will assist you.

Sincerely,

Mitchell McAllister
Medicare B Provider Certification

Palmetto GBA

Post Office Box 100190, Columbia, South Carolina 29202-0190
A HCFA Contracted Intermediary and Carrier

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

In the Matter of:

Hugh S. Thompson, M.D.,

Medical License #7087,

Licensee.

PRIVATE AGREEMENT

WHEREAS, Licensee has advised the Board of a commitment to a life of sobriety and willingness to submit at Licensee's expense to such tests and other conditions as the Board may desire, from time to time, to assure it of Licensee's continued compliance with that commitment.

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the South Carolina Medical Association, or a successor program approved as such by the Board (hereinafter the Program). Such contract shall specify the required frequency of attendance at support groups, or other such activities as the Program shall deem appropriate, including, but not limited to:

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- (2) Alcoholics Anonymous (AA) or Narcotics Anonymous (NA);
- (3) Caduceus support groups or its equivalent approved by the Board;
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- (e) Licensee shall appear and report to the Board as requested by the Board.
- (f) Licensee shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Agreement. Correspondence and copies of reports and notices mentioned herein shall be directed to:

LLR-Board of Medical Examiners
P. O. Box 11289
Columbia, SC 29211-1289

2. It is understood and agreed that by executing this Agreement, Licensee specifically consents to execute and to deliver to the Board, within ten (10) days of request, an authorization for the release to the Board of any and all records, reports, or other information concerning Licensee by any and all persons or entities involved, notwithstanding any privilege provided by federal or state law. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

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8. It is further understood and agreed that this Agreement does not satisfy, prejudice, or stay any disciplinary action currently pending before the Board or which may be filed in the future.

AND IT IS SO AGREED.

Effective: 4-9-98
4/8/98
Date

STATE BOARD OF MEDICAL EXAMINERS

BY: Hartwell Z. Hildebrand
HARTWELL Z. HILDEBRAND, M.D.
President of the Board

I AGREE:

[Signature] M.D.
LICENSEE

4/8/98
Date

Karen Newton
WITNESS OR ATTORNEY

4/8/98
Date

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF MEDICAL EXAMINERS

In the Matter of:)

HUGH SMITH THOMPSON, M.D.)

Medical License #7087,)

Respondent.)

FINAL ORDER

STATEMENT OF THE CASE

On or about June 7, 1993, the Executive Director of the Board of Medical Examiners (the Board) served and filed a Notice and Complaint against Hugh Smith Thompson, M.D. (Respondent), who is a physician duly licensed by the Board to practice medicine in South Carolina. On or about November 8, 1993, a Notice and Amended Complaint was served and filed against Respondent. On or about January 12, 1994, after proper notice, a hearing was held before a panel of members of the Medical Disciplinary Commission pursuant to S.C. Code Ann. §40-47-200 (Supp. 1993) and Regulations No. 81-15 and 81-16. Following Receipt of the Hearing Panel's Report, a Final Order Hearing was noticed and held on Wednesday, May 18, 1994, at the Board's Office located at the Koger Center, 101 Executive Center Drive, Suite 120, Columbia, South Carolina. Respondent appeared with counsel, Celeste T. Jones, Esquire. The State was represented by associate counsel Clifford O. Koon, Jr., Esquire, and Deputy General Counsel Richard P. Wilson.

The Board hereinbelow makes specific findings of fact regarding the issues involved in this matter. The findings are specifically based on the Board's review of the exhibits admitted into evidence and the testimony presented.

FINDINGS OF FACT

The Board finds:

1. Respondent is a physician duly licensed by the Board to practice medicine in South Carolina. He currently resides in Darlington, South Carolina. Respondent previously practiced anesthesiology in Florence, South Carolina, until he ceased active practice on or about April 30, 1992.

2. Respondent's case concerns the prescribing of quantities of various controlled substances and other dangerous drugs including Tylox, Lortab, Vicodin, Darvocet-N 100, Tagamet, and Darvon over an approximately 26 month period to an alleged patient outside a bona fide physician-patient relationship and without documented medical justification or need.

3. Respondent testified that he and Patient A were close personal friends who dated each other during the period under review. Respondent further testified that he had seen her socially 6 to 10 times prior to November 28, 1990, when she first requested pain medication from him. Although she lived in Columbia, she approached Respondent in Darlington allegedly because of her trust in him from their personal relationship and her concern for strict confidentiality due to her job situation which was sensitive to any allegation of personal drug abuse. Respondent further admitted that he was aware at that time of her history of substance abuse. Respondent stated that he nevertheless agreed to her request because of their close personal relationship and because he believed she was genuinely in pain.

4. Their arrangement was for her usually to telephone Respondent in Darlington and he, in turn, would telephone his authorization for drugs to a pharmacy in Columbia for her to

pick up. Respondent also admitted that sometimes at their social meetings she would tell him about her pain and then he would call-in a prescription for her, as requested.

5. Prescription documents found at a Columbia pharmacy reveal that between November 28, 1990, and January 6, 1993, Respondent called-in approximately 45 prescriptions for Patient A, principally for Schedule III narcotic analgesics, such as Lortab and Vicodin.

6. Respondent admitted that he never saw Patient A in a medical setting and never did a full history and physical examination of her. Respondent did not produce any medical record concerning the care he allegedly rendered to her and kept virtually no record of the drugs he prescribed for her.¹ Among other things, Respondent did no appropriate workups, kept no progress notes, and had no treatment plan to justify the medical need and purpose for the drugs he prescribed for her.

7. In response to a question from the Panel, Respondent admitted that he did not think of himself as a member of her treatment team. Therefore, Respondent apparently never advised other physicians, who were known by him to be actively treating Patient A for her medical problems, that he was supplying her with additional drugs which could mask some of the symptoms and causes they were attempting to treat.

¹ Respondent's record of the care he rendered during the approximately 26 month period under review consists of only seven (7) very brief references to quantities of Vicodin ES he prescribed during the last three months. The remaining documents in Respondent's record were portions of hospital records she had provided concerning some of her surgeries at various times during the period under review which documented her history of chronic pain. Those hospital records contain no reference to Respondent as a referring physician, consultant, or anesthesiologist. Additional hospital records concerning Patient A subsequently obtained for the Panel Hearing also are devoid of any reference to Respondent.

8. Respondent also appeared and testified under oath before the Board. Respondent admitted, among other things, that he had no "conventional" physician-patient relationship with Patient A. Respondent testified that the only physical examinations conducted by him were done "informally" in her home with someone else present. Respondent asserted that he once had medical records concerning Patient A's care, but that they must have been lost. However, it was conceded that there are no medical records in this record to support Respondent's position. Respondent further admitted that he knew of the prohibition of State law against prescribing controlled substances for family and close personal friends, and that he had become uncomfortable doing so in this case. However, Respondent testified that he continued prescribing to Patient A because of their personal relationship. Respondent further admitted that, although the physician is supposed to be in control, sometimes he was not. The record reveals that Respondent's only involvement was to supply Patient A with the drugs she requested.

9. Accordingly, the Board finds that there is no evidence of a bona fide physician-patient relationship between Respondent and Patient A. The Board further finds that Respondent's prescribing to Patient A was not in the usual course of professional practice and was below the professional standard of care in similar situations.

CONCLUSIONS OF LAW

The Board concludes that Respondent has violated S.C. Code Ann. §§40-47-200(7), (8), (11) and (12) (1986); Regulation No. 81-60(A), (D), (F), and (G) (1986); Regulations No. 81-

60(C), (D), and (E) (Supp. 1992) of the Rules and Regulations of the Board; and S.C. Code Ann. §§44-53-360 (c) and (h) (1986).

SANCTION

In enforcing the Medical Practice Act, the Board is mindful that its ultimate purpose is to protect the public and maintain the integrity of the profession in the State. In fashioning an appropriate sanction, this Board has meticulously weighed the public interest and the need for services of qualified medical doctors against the countervailing concern that society be protected from professional misconduct.

Respondent's misconduct involves the unlawful and inappropriate prescribing of controlled substances outside a bona fide physician-patient relationship and not in the usual course of his practice. In addition to raising serious questions regarding his professional competence, Respondent's misconduct threatened the public health and subverted the laws governing the use of controlled substances.

Accordingly, the Board finds it is in the public interest to impose the following sanction.

THEREFORE, IT IS ORDERED THAT:

1. Respondent's license to practice medicine in this State is hereby suspended for an indefinite period. Said suspension shall be stayed and Respondent's license reinstated in a probationary status only after Respondent has satisfied the following specified precondition for reinstatement:

(a) Respondent shall pay a fine of Five Thousand and No/100 (\$5,000.00) Dollars.

Said fine shall not be deemed paid until received by the Board.

2. Thereafter, Respondent's license shall be reinstated in a probationary status for an indefinite period of time upon the following terms and conditions of probation, which shall remain in effect until further Order of the Board:

- (a) Within thirty (30) days of the date of this Final Order, Respondent shall enter into a Consent Order or Agreement with the Bureau of Drug Control, South Carolina Department of Health and Environmental Control (the Department), restricting his Controlled Substances Registration in all schedules to institutional use only. This restriction is designed and intended to prohibit Respondent from prescribing controlled substances outside a hospital or clinic licensed by the Department. Compliance shall not be deemed complete until a copy of said Consent Order or Agreement is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Respondent's license to practice medicine until such time as full compliance has been made by Respondent.
- (b) Respondent shall use triplicate copies of prescriptions for all controlled substances written by him. One copy shall be delivered to the patient; one copy shall be placed in the patient's hospital or clinic record; and one copy shall be maintained by Respondent in a readily retrievable manner for inspection by representatives of the Board or other appropriate authorities. The last copy shall be delivered by Respondent to the Board upon request at such times as the Board may desire.

3. Failure by Respondent to abide by any of the aforementioned conditions of probation during said period shall warrant the immediate revocation of probation and the immediate imposition of the aforementioned indefinite suspension of his license to practice medicine in this State pending hearing into the matter and until further Order of the Board.

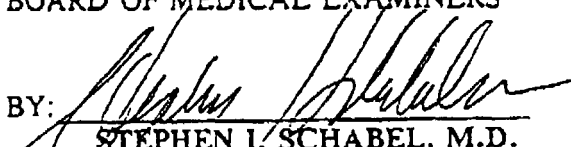
4. Respondent shall cooperate with the Board, its attorneys, investigators, and other employees in the investigation of Respondent's practice and compliance with the provisions of this Final Order. It is Respondent's responsibility to demonstrate compliance with each and every provision of this Final Order. Respondent may be required to furnish the Board with additional information as may be deemed necessary by the Board or its representatives. In addition to such requests the Board, in its discretion, may require Respondent to submit further documentation regarding Respondent's practice, and it is Respondent's responsibility to fully comply with all such requests in a timely fashion. Failure to satisfactorily comply with such requests will be deemed a violation of this Final Order.

5. This Final Order shall take effect immediately upon receipt by Respondent or his counsel.

AND IT IS SO ORDERED.

SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING AND REGULATION
BOARD OF MEDICAL EXAMINERS

BY:


STEPHEN I. SCHABEL, M.D.
President of the Board

May 31, 1994.

- (c) Respondent's medical records (office, hospital, and surgical activity) shall be subject to periodic review by Board representatives. The cost of such reviews shall be borne by Respondent.
- (d) Respondent shall appear and report to the Board as requested by the Board.
- (e) Within one (1) year of the date of this Final Order, Respondent must attend and document completion of the Clinical, Legal, and Ethical Issues in Prescribing Abusable Drugs program offered by the Florida Medical Association and the University of South Florida, or an equivalent course approved in advance by the Board. Respondent must file written proof of compliance with the Board within fifteen (15) days after completing this requirement. Failure to comply with this requirement shall automatically result in the immediate temporary suspension of Respondent's license to practice medicine until such time as full compliance has been made by Respondent.
- (f) Respondent shall comply with the terms of this Final Order and all State and Federal statutes and regulations concerning the practice of medicine.
- (g) Respondent shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Final Order. Correspondence and copies of reports and notices mentioned herein shall be directed to:

South Carolina Department of Labor,
Licensing & Regulation
Board of Medical Examiners
P. O. Box 212269
Columbia, SC 29221-2269



State of South Carolina

Department of Health and Human Services

David M. Beasley
Governor

July 14, 1998

Gwen Power
Director

CERTIFIED MAIL

Hugh S. Thompson, M.D.
111 N. Ervin Street
Darlington, SC 29532

RE: Reinstatement in the South Carolina Medicaid Program

Dear Dr. Thompson:

Based on the action taken by the South Carolina Department of Labor, Licensing and Regulation - Board of Medical Examiners, you are being reinstated in the South Carolina Medicaid Program. This action is retroactive to April 14, 1998, the date of the Reinstatement issued by the Board.

Sincerely,

A handwritten signature in black ink, appearing to read "Gwen Power", written over a horizontal line.

Gwen Power
Director

GP:cm

cc: Ms. Carolyn G. Jordan, Chief
Bureau of Medicaid Program Assessment
Ms. Darlynn Thomas, Chief
Bureau of Health Services
Department Head, Program Development
Bureau of Community Services

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 253-6100 • Fax (803) 253-4137

FROM :

FAX NO. :

Mar. 04 1999 11:55AM P1

ATTN

SUSAN

Tom Marchant

A S S O C I A T E S

Real Estate • Land Development
LICENSED IN NORTH & SOUTH CAROLINA

3.4.99

TO: HUGH THOMPSON
FROM: TOM MARCHANT

CONTRACT ON LOT 262

PLEASE SIGN INITIAL WHERE NOTED
BY → AND RETURN.

SEE YOU TONIGHT.

Phone: 864/250-1800 Fax: 864/250-1808 Pager: 864/413-0040

CONTRACT FOR SALE OF LAND ON LOT

DATE: A Contract to purchase is offered this 22 day of FEB 1999 by HUGH THOMPSONto MICHAEL K. ARMSTRONGAGREEMENT AND DISCLOSURE: Purchaser agrees to buy and Seller agrees to sell all that lot or parcel of land, with the buildings and improvements thereon, if any, located in CLIFF RIDGE, South Carolina and being described as follows: LOT 2 P&Z CLIFF RIDGE TR, CLIFF RIDGE, S.C.PRICES: The sales price is 14,000
(1) \$ 14,000 Earnest money held in trust by TOM MARCHANT ASSOCIATES
(2) \$ 0 Additional cash at closing
(3) \$ 0 Loan Amount to be obtained by Purchaser
(4) \$ 0 Sales Price

CONVEYANCE AND CLOSING DATE: Seller agrees to convey by marketable title and deliver a proper general warranty deed with all encumbrances of record or on the premises (provided they do not make the title unmarketable) and to all persons entitled to the same, including the state and local governments. The deed shall be prepared in the name(s) and delivered to the name(s) of the purchaser.

POSSESSION: Possession of said premises will be given to Purchaser on or before APRIL 1, 1999

EARNEST MONEY: If any contingency of the Contract is not satisfied through no fault of Purchaser, or if a binding Contract is not executed by either party, the deposit of funds has cleared the account of the broker holding the funds. All such monies deposited shall be returned to Purchaser on or before the next business day after acceptance of the offer of a sales contract. The listing and selling of real estate is not a contract. Payment of earnest money is not a contract. The broker holding the earnest money deposit will not disburse it to either party until both parties have executed a sales contract. The deposit of funds is not a contract.

ADJUSTMENT: Taxes, water charges, or other utilities, such as when possession is given, shall be adjusted on the date of closing. The purchase price to the Contract is based on the last actual date of payment on the date of closing and go to be adjusted to that date. All other taxes shall be paid by the purchaser.

DISCLAIMER: I, the Purchaser, declare under the penalty of perjury that I have read this contract and understand its contents. I agree to the terms and conditions of this contract and to the fact that I am purchasing the property described herein for my own use and not for resale. I agree to the fact that I am purchasing the property described herein for my own use and not for resale. I agree to the fact that I am purchasing the property described herein for my own use and not for resale.

SURVEY, TITLE, ENCUMBRANCES AND DISCLOSURE: The Seller has provided a copy of the survey and title report to the Purchaser. The Seller has provided a copy of the survey and title report to the Purchaser. The Seller has provided a copy of the survey and title report to the Purchaser.

GOOD FUND AT CLOSING: It is agreed by the parties that at the time of closing, the Purchaser may be required to provide cash or other funds to complete the transaction.

DISCLAIMER BY BROKERS AND AGENTS: THE BROKERS AND AGENTS HAVE BEEN ADVISED THAT THE LISTING AND SELLING BROKERS AND THEIR AGENTS DO NOT GUARANTEE OR WARRANT THE ACCURACY OF ANY INFORMATION OR THE PERSONAL CONDITION OF THE PROPERTY OR AS TO THE EXISTENCE OF AN ENCUMBRANCE OR THE EXISTENCE OF ANY OTHER MATTER THAT MAY AFFECT THE PURCHASE OF THE PROPERTY.

THIS IS OF RECORD BEFORE CONTRACT: This is of record before contract. This is of record before contract. This is of record before contract.

THIS IS OF RECORD BEFORE CONTRACT: This is of record before contract. This is of record before contract. This is of record before contract.

REMARKS: Positive for taxes produced / purchase to
include purchase of 2.13 acres and 1.13 acres
to add lot 1.13 acres and 1.13 acresADDITION: ATTACHED YES ☒ NO ☐ IF YES, NUMBER OF ADDITIONAL PAGES DISCLOSED

If Purchaser and Seller both initial this sentence, each agrees that receipt of a signed contract by telecopy (FAX) within the same or receipt of a signed contract.

THIS IS A LEGALLY BINDING CONTRACT. PURCHASER AND SELLER SHOULD SEEK LEGAL ADVICE IF THE CONTENTS ARE NOT UNDERSTOOD. BOTH PURCHASER AND SELLER ACKNOWLEDGE THE RECEIPT OF A COPY OF THIS CONTRACT. SIGNATURES OF ALL PARTIES MUST BE OBTAINED.

Witness to Purchaser	DATE	SIGNATURE	DATE	SIGNATURE
Witness to Seller	DATE	SIGNATURE	DATE	SIGNATURE
Listing Office	DATE	SIGNATURE	DATE	SIGNATURE
Selling Office	DATE	SIGNATURE	DATE	SIGNATURE

Listing Agent: John N. Marchant Phone # 864/250-1800
Selling Agent: John N. Marchant Phone # 864/250-1800

TOM MARCHANT ASSOCIATES
BOX 818 / GREENVILLE, SOUTH CAROLINA 29602 / 864-271-2222
CLIFF RIDGE 864 / 538-4004 DIGITAL PAGER 864 / 413-0040



DISCLOSURE AND CONSENT TO DUAL AGENCY

Brokerage Company TOM MARCHANT ASSOCIATES
(Print or type)Licensee TOM MARCHANT
(Print or type)Seller MICHAEL K. ARMSTRONG
(Print or type)Buyer HUGH S. THOMPSON
(Print or type)Property Location LOT # 262 CLIFF RIDGE DR.
(Print or type)CLIFF RIDGE AT CESAR'S HEAD, S.C.

LICENSEE/COMPANY DISCLOSURE: PRIOR TO MAKING THIS REQUEST FOR CONSENT TO ACT AS A DUAL AGENT REPRESENTING BOTH SELLER/CLIENT AND BUYER/CLIENT IN THE SAME REAL ESTATE TRANSACTION INVOLVING THE ABOVE-STATED LOCATION, UNDERSIGNED LICENSEE/COMPANY HAS SEPARATELY INFORMED BOTH SELLER/CLIENT AND BUYER/CLIENT ABOUT THE LIMITED DUTIES OF A DUAL AGENT; AND HAS ADVISED THAT THE DUAL AGENT MAY NOT BE AN ADVOCATE FOR EITHER PARTY AND MAY NOT DISCLOSE TO ONE PARTY ANY INFORMATION GAINED FROM THE OTHER PARTY IF THE INFORMATION CONCERNS: WILLINGNESS OR ABILITY OF SELLER TO ACCEPT LESS THAN THE ASKING PRICE; WILLINGNESS OR ABILITY OF BUYER TO PAY MORE THAN THE OFFERED PRICE; CONFIDENTIAL NEGOTIATING STRATEGY NOT DISCLOSED IN AN OFFER AS TERMS OF A SALE; MOTIVATION OF SELLER FOR SELLING OR MOTIVATION OF BUYER FOR BUYING.

SELLER OR BUYER ACKNOWLEDGMENT AND CONSENT: SELLER OR BUYER BY SIGNING BELOW ACKNOWLEDGES THAT HE OR SHE HAS BEEN INFORMED BY LICENSEE/COMPANY ABOUT DUAL AGENCY AND THE LIMITED DUTIES OF A DUAL AGENT. SELLER OR BUYER HEREBY AGREES TO MODIFY ANY PRIOR AGENCY DISCLOSURE ACKNOWLEDGMENTS AND AGENCY REPRESENTATION AGREEMENTS WITH LICENSEE/COMPANY TO THE EXTENT THAT SELLER OR BUYER DOES VOLUNTARILY GIVE CONSENT FOR LICENSEE/COMPANY TO ACT AS A DUAL AGENT REPRESENTING BOTH SELLER AND BUYER ONLY IN THE REAL ESTATE TRANSACTION IN WHICH MICHAEL K. ARMSTRONG

(Name of Seller)

IS THE SELLER AND HUGH S. THOMPSON

(Name of Buyer)

IS THE BUYER OF PROPERTY AT THE ABOVE-STATED LOCATION. SELLER OR BUYER FURTHER ACKNOWLEDGES RECEIPT OF A SIGNED COPY OF THIS FORM.

SIGNATURE

(Date)

(Seller or Buyer)

(Date)

(Seller or Buyer)

2-28-99

(Date)

(Licensee)

This form is promulgated by the South Carolina Department of Labor, Licensing and Regulation, Real Estate Commission for mandatory use by real estate licensees. It may be reproduced but may not be modified or altered in any way.

(007)

The American Board of Anesthesiology

Hereby certifies that

Hugh Smith Thompson

a licensed Graduate of Medicine, having complied with all the requirements of this Board, is qualified to serve as a consultant in Anesthesiology.

Given this third day of October, 1980



Robert H. Entlin, M.D.

President

Orel B Crawford, M.D.

Vice-President

E. L. Lohr, M.D.

Secretary-Treasurer



Certificate No. 9785

The American Board of Anesthesiology

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Hugh Smith Thompson

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Given this third day of October, 1980



Ronald E. Enrie, M.D.

President

Oral B. Crawford, M.D.

Vice-President

E. L. H. M.D.

Secretary-Treasurer



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Robert L. Ennis, M.D.

President

Orvil B Crawford, M.D.

Vice-President

E. L. L. M.D.

Secretary-Treasurer



Certificate No. 9785

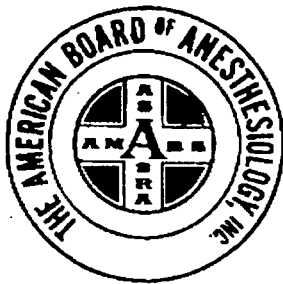
The American Board of Anesthesiology

Hereby certifies that

Hugh Smith Thompson

a licensed Graduate of Medicine, having complied with all the requirements of this Board, is qualified to serve as a consultant in Anesthesiology.

Given this third day of October, 1980



Robert H. Ennis, M.D.

President

Orel B Crawford, M.D.

Vice-President

E. L. L. M.D.

Secretary-Treasurer



Certificate No. 9785

Fellow-in-Anesthesiology

THE AMERICAN



COLLEGE OF

ANESTHESIOLOGISTS

OF

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

This is to certify that

Hugh Smith Thompson, M.D.

a duly licensed Physician, having complied with all the requirements of

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS,

and having demonstrated to its satisfaction an adequate preparation and experience together with special knowledge of the art and science of Anesthesiology, and being proficient in the practice of this specialty is hereby admitted as a

Fellow of The American College of Anesthesiologists

BY EXAMINATION

John S. Hattery M.D.
President, A.S.A.

Richard J. Ward M.D.

8283

Eugene C. Nayel M.D.

SUMMARY OF EVENTS and OBSERVATIONS
HUGH S THOMPSON, MD

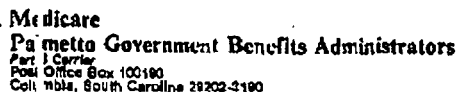
1. I concede, that in 1996 I received from US Health and Human Services, or the office of the US Inspector General, a letter informing me of the expiration of my status as a Medicare provider. This document addressed procedures for reinstating such status. I concede, as well, that I do not now have this document, and that I had completely forgotten it by the spring of 1998, when I was in the process of resuming medical practice. At the time I received it, I was not planning to resume medical practice, was going through a business failure and was sustaining grievous financial losses. I also concede that I relied on office personnel who I had reason to believe were conversant with Medicare regulations and procedures through daily contact with Medicare and other third party carriers, and whose specific duties were to deal with operational details of billing, coding, and credentialing. I further concede a my ignorance of such details. With this help, I executed what I believed to be the appropriate documents for recredentialing. I have never had reason to think those persons assisting me had any reason to deliberately misrepresent anything, or to take clerical "shortcuts" to expedite the process. I do know that during this process, the office manager had several conversations with people in the offices involved in the process in order to get instructions and assure that the process was correctly completed. I had no reason to think that the process we went through was not the proper one, or was incomplete.
2. I received a letter from Palmetto Government Benefits Agency in May" (?) of 1998 informing me that my status as a provider was approved, and providing the necessary code numbers for billing.
3. My employers' insurance and business personnel began to bill for my services using the numbers provided. Eventually, billings originated from five offices. At each office, I executed a form for the assignment of benefits to the employer (again with the guidance of office personnel). For a period of about three and one half years, through five separate employers, to the best of my knowledge, all claims were paid. I was never made aware of any sort of problem with my credentialing or with the billing/ collection process. This fact does not seem to me to be consistent with "exclusion" from the system. Further, immediately after completing machinations to correct the problem when I was made aware of it (to be addressed), I was notified by Palmetto Government Benefits Agency (PGBA) in March of 2002 (3 1/2 years later) that my status as a provider was revoked, was invalid, or was "excluded" (I am uncertain of the exact terminology). I submit that I could not have been "excluded" unless, at some point, I had been "included". I would conclude that the period of "inclusion" spanned the time from receipt of the letter from PGBA issuing the numbers to their (PGBA) notification of the revocation or "exclusion".
3. In March of 2002, at which time I was made aware that something was awry in my status, Dr. Banks made enquiries of PGBA three separate times, and was each time informed that no problem existed. Dr. Banks and I then communicated with the Office of the Inspector General to ascertain the nature of the problem and steps to take to rectify it. We were provided with forms to submit which contained several questions that office required answers for. I answered these to the best of my knowledge and understanding of the questions. We were informed by that office that the problem had been satisfactorily rectified. Immediately after we received such information, we were notified by PGBA that my status was invalid. We were then required to execute another form for PGBA, which was done, after which we were notified that the problem at PGBA had been rectified. Dr. Banks retained counsel for First Choice Healthcare to assure satisfactory compliance, and, I believe it was his impression that the problem had been satisfactorily resolved.
4. On May 24, 2004, more than two years after I had been assured that all was in order, I was interviewed by an investigator from the Office of the Inspector General of Health and Human Services and was presented with a number of the involved documents. It was quite obvious to me that the investigator had prepared himself for a particular line of interrogation, as all the documents he presented were neatly and carefully arranged in a ring binder in the order he presented them. He did not advise me that I might need counsel.

One of these documents (studied to above as the one submitted to the Office of the Inspector General for the purpose of rectifying the problem) contained a question having to do with the identity of my employers during the period of my "exclusion". The investigator's line of questioning then indicated to me quite strongly that he concluded I had deliberately and knowingly falsified the answer to that question. While he was not discourteous in his tone or manner, I understood the content of his responses to be threatening. A good deal of his questioning concerned the word "exclusion", its use in these documents, and my interpretation of it. During this interview, I expressed, somewhat strongly, my frustration and anger at the investigator's contention. I am told by a third party that the investigator and his companions interpreted this expression as representing "a flagrant disregard for the Law", which it most certainly was not. It was, exactly as I have said, an expression of my exasperation and fury at dealing with a system so full of snags and pitfalls that it makes honest practitioners and those with criminal intent equally vulnerable. I regret the misapprehension of my statements, but offer no apology for my sentiments.

5. I am prepared to offer this statement under oath, as a summary of my position in this affair:

I executed all forms submitted to Government and Government Contractors' offices with as much accuracy as my understanding allowed, and with an intent to comply fully with all that was required of me. I performed the services which were billed for, all of which were medically necessary, in good faith, and at no time when such billings were submitted had any awareness that any problem, technical, clerical or other, existed in my status as a Medicare provider. At no time did I deliberately and knowingly attempt to deceive or mislead for any personal gain or any other purpose. I performed honest work to the best of my ability, and always operated under the conviction that I was entitled to the remuneration I received for the service that I rendered.

Hugh S. Thompson, M.D.
111 North Ervin Street
Darlington, S.C. 29532
May 28, 2004



Hugh S. Thompson, M.D.
P.O. Box 875
Marion, SC 29571-0875

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and or practitioner(s). The number(s) listed below have the participation status of the group practice. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

If you are filing claims electronically please contact our Electronic Data Interchange (EDI) department at (803) 788-9751 to update your EDI Enrollment Form.

If we may be of further assistance please call our Medicare Part B Customer Service Center at (803) 788-3568. A customer service representative will assist you.

Gina X. 114
Medical & B Provider Certification

PROB. 942, ETCOPAC, 22890 ISSU79.70J, 5490

7A : 7944 RE: IN FILE 10-20-49

FAX:

: 14062

PAGE 22

Part A: Intermediate
Part B: Carrier
Part C: Regional Carrier

Firstchoice Healthcare
Attn: Robert Lafreniere
734 West Carolina Ave.
Hartsville, SC 29550-4412

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and/or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and/or practitioner(s). The number(s) listed below have the status of the group practice, which is Participating. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Provider Name	Provider Number	Effective Date	Expiration Date
Changho Kang	G323106873	November 1, 2000	N/A
Kent Voelar	F60E176873	November 1, 2000	N/A
Hugh Thompson	D993216873	November 1, 2000	N/A
Willard Banks	U300826673	November 1, 2000	N/A
Ryan Mitchell	U791806873	November 1, 2000	N/A
Steven Rollenbeck	Q324396873	November 1, 2000	December 31, 2000
Robert Lafreniera	U758756873	November 1, 2000	N/A
Robert Lafreniera	U758756672	November 1, 2000	N/A

**Our new group number is 6873. Please use it for the following locati
754 West Carolina Avenue Hartsville, SC 29550

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

Palmetto Government Benefits Administrators, LLC
Post Office Box 100190, Columbia, South Carolina 29208-3190
A HCFA Contracted Intermediary and Carrier

HICFA

Part A Intermediate
Part B Certificate
Diploma Regional Certificate

Advanced Medical Associates of Georgetown
Attn: John Davila
722 W. Fraser Street
Georgetown, SC 29440-3353

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and/or practitioner(s) to your group practice(s). In accordance with your request we have approved and assigned a provider billing number for the physician(s) and/or practitioner(s). The number(s) listed below have the status of the group practice, which is Participating. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Rachel E. Kramer
Rachel Kramer
Medicare B Provider Certification

Palmetto Government Benefits Administrators, LLC
Post Office Box 100180, Columbia, South Carolina 29202-180
A MCA Contracted Intermediary and Carrier

68880 0143790161-0879000129-701-0000

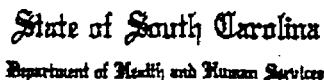
T.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF HEALTH SERVICES

722 N FRASER ST
SEORGETOWN SC 29440

POST OFFICE BOX 8809
COLUMBIA, S.C. 29202-6809
(803) 768-1622 FAX 41630

THIS NUMBER IS USED FOR TAX REPORTING. PLEASE VERIFY.

630



July 14, 1998

CERTIFIED MAIL

Hugh S. Thompson, M.D.
111 N. Earl Street
Darlington, SC 29532

RE: Reinstatement in the South Carolina Medicaid Program

Dear Dr. Thompson:

Based on the action taken by the South Carolina Department of Labor, Licensing and Regulation Board of Medical Examiners, you are being reinstated in the South Carolina Medicaid Program. This action is retroactive to April 14, 1998, the date of the Reinstatement issued by the Board.

Sincerely,

**Given Power
Director**

GP:gm

cc: Ms. Carolyn G. Jordan, Chief
Bureau of Medicaid Program Assessment
Ms. Darynn Thomas, Chief
Bureau of Health Services
Department Head, Program Development
Bureau of Community Services

Office of the Director
P.O. Box #206 - Columbia, South Carolina 29202-0206
(803) 253-6100 - Fax (803) 253-4137

MEDICARE

Part A Intermediary
Part B Carrier
CME Regional Carrier

DATE: August 19, 2002

Firstchoice Healthcare
Attention: Dean Banks
2013 Second Loop Road, Unit F
Florence, SC 29501-6182

Dear Mr. Banks:

We have received an enrollment form or Reassignment of Benefits in order to affiliate physician(s) and/or practitioner(s) to your group practice(s). In accordance with your request We have approved and assigned a provider billing number for the physician(s) and/or practitioner(s). The member(s) listed below have the status of the group practice, which is Participating. If a member has an expiration date listed, please submit a copy of his/her renewed license prior to the date indicated. Listed below you will find the provider's name, number, effective and expiration date for each.

Provider Name	Provider Number	Effective Date	Expiration Date
Hugh Thompson	D993216873	June 20, 2002	N/A
Reactivated to group	#6873, 754 WEST CAROLINA AVENUE, HARTSVILLE, SC		
Hugh Thompson	D993216672	June 20, 2002	N/A
Reactivated to group	#6672, 2013 SECOND LOOP ROAD, UNIT F, FLORENCE, SC		

Please use the above provider number(s) on all Medicare Part B claims and correspondence.

If you are filing claims electronically please contact our Electronic Data Interchange (EDI) department toll free at 1-866-749-4301 to update your EDI Enrollment Form.

If we may be of further assistance, please call our Medicare Part B Customer Service Center toll free at 1-866-238-9634. A customer service representative will be happy to assist you.

Sincerely,

Salem Matheson-Jackson
Salem Matheson-Jackson
Medicare B Provider Certification

REF 11144027

Palmello GBA
Post Office Box 100190, Columbia, South Carolina 29202-3190
A CMS Contracted Intermediary and Carrier

01400, 0122500078, 22595007879, 779, 2200

TO : JMW FROM : FBI 100-471

: FAX :

: WORLD

63

00000, 90225910550, 120100055077, 781, 360M

Wes Jackson
Associate
Admitted in SC, NC

June 15, 2007

BY HAND DELIVERY AND CERTIFIED MAIL

Palmetto GBA
Medicare Part B Appeals
P.O. Box 100190
Columbia, South Carolina 29202-3190

Re: Request for Redetermination and Withhold Objection

To Whom it May Concern:

Our firm represents FirstChoice Healthcare ("FirstChoice"). FirstChoice received an overpayment demand letter ("Overpayment Letter") on May 30, 2007. The Overpayment Letter, which is attached as Exhibit A, stated that FirstChoice has received an overpayment by Medicare in the amount of \$101,650.14. Pursuant to the terms of your letter and the applicable statutes and regulations, please allow this letter to serve as FirstChoice's request for redetermination of the overpayment determination and a formal request that the withhold not be implemented. Because FirstChoice is well within the one-hundred twenty (120) day deadline for filing its request for redetermination, it reserves the right to supplement this request.

Request for Redetermination

As the basis for this alleged overpayment, the Overpayment Letter states that FirstChoice received Medicare Part B payments for services provided by Dr. Hugh Thompson from March 31, 1996 to June 20, 2002, during which time, Dr. Thompson was excluded from participating in the Medicare program.

The excluded provider designation was imposed as a result of the suspension of Dr. Thompson's license to practice medicine after Dr. Thompson refused to pay a fine owed to the South Carolina Board of Medical Examiners. Dr. Thompson paid this fine and his license was reinstated in 1998. Unfortunately, Dr. Thompson was unaware that he was required to file any additional paperwork and thus failed to complete the appropriate paperwork to remove his name from the OIG's excluded provider list. Thus, while he had satisfied all the necessary criteria to obtain

Palmetto GBA
June 15, 2007
Page 2

reimbursement from Medicare and obtained the appropriate permission to do so, he was still erroneously listed as an excluded provider.

Dr. Thompson and FirstChoice first became aware of Dr. Thompson's presence on the OIG's excluded provider list in 2002 when Dr. Thompson referred a Medicare patient for physical therapy in North Carolina. The practice manager of the physical therapy practice called FirstChoice and indicated that she received a letter from HCFA that Dr. Thompson was excluded from Medicare effective March 31, 1996. Up and until the point the physical therapy practice manager notified FirstChoice of Dr. Thompson's excluded provider status, Dr. Thompson and FirstChoice had no knowledge of any such designation.

Please note that in 1998 when Dr. Thompson began part-time work for FirstChoice, Dr. Thompson filed an 855-1 and an 855-R form, both of which were accepted. Additionally, in November 2000 FirstChoice opened a satellite office which received a group Medicare number and to which Dr. Thompson was allowed to reassign his benefits under the 855-R. Further, in 2001 Dr. Thompson filed and received Railroad Medicare Provider status. At the time these applications were submitted, neither Dr. Thompson nor FirstChoice were aware that Dr. Thompson was on the excluded provider list. Thus, there was no reason for Dr. Thompson or FirstChoice to doubt Dr. Thompson's status as an approved Medicare provider upon the approval of the above-referenced applications.

Prior to Dr. Thompson's employment with FirstChoice, Dr. Thompson had worked at two other medical clinics, Fowler Health Clinic and The Pee Dee Group, both of which had submitted the appropriate paperwork to Palmetto GBA ("PGBA") and had received notification that Dr. Thompson was in good standing and reassignment of benefits to their respective group numbers were permitted by PGBA. FirstChoice was provided with copies of the acknowledgement of reassignment of benefit when Dr. Thompson began his employment with FirstChoice.

In response to the practice manager's discovery, FirstChoice called Palmetto GBA and spoke to Tina Houser (803.786.1034, ext. 34620), who informed FirstChoice that Dr. Thompson was in good standing with Medicare and that FirstChoice could bill and be reimbursed in South Carolina. Dr. Thompson had further conversations with the OIG and HCFA and was sent a reinstatement form in February 2002, which indicated that FirstChoice could not participate in Medicare or Medicaid until the reinstatement was completed. FirstChoice again called Palmetto GBA and was told that Dr. Thompson's Medicare number was active and that FirstChoice could bill Medicare for Dr. Thompson's services.

Palmetto GBA
June 15, 2007
Page 3

In July 2002 FirstChoice received an Explanation of Benefits denying payment on all of Dr. Thompson's patients with an explanation that he was not certified for the procedure/service on the date of service. FirstChoice contacted Palmetto GBA once again and this time was informed that Dr. Thompson was excluded from Medicare from March 1996 until June 2002. FirstChoice was also told that repayment of Medicare funds received during that time would be owed and that FirstChoice would be turned over to the fraud investigation department.

In 2004, our firm represented FirstChoice in discussions with Jennifer Aldrich in the U.S. Attorney's Office regarding this matter. At that time, Ms. Aldrich informed us that there was no intention to seek repayment from FirstChoice due to Dr. Thompson's designation as an excluded provider. At that time, due to the representation of the U.S. Attorney's Office, FirstChoice and Dr. Thompson considered the matter closed.

FirstChoice respectfully submits that CMS' demand for repayment is barred under applicable federal law. In this case, there were multiple occasions where Dr. Thompson and FirstChoice made inquiries regarding Dr. Thompson's status and on almost every occasion, they were informed that he was eligible to participate. When they were informed that he was not eligible, Dr. Thompson and FirstChoice took appropriate remedial action and willingly participated in Government investigations regarding the matter.

FirstChoice and Dr. Thompson relied on the Government's actions and began and continued billing Medicare for services provided by Dr. Thompson. The CMS Fiscal Intermediary Manual and OIG guidance mandate that carriers confirm that the provider is not excluded from the Medicare program when reviewing provider enrollment forms. This is a key component of ensuring that the applicant is eligible for a Medicare provider number. When Dr. Thompson's 855-I and 855-R were accepted, CMS committed affirmative misconduct as it should have alerted Dr. Thompson and FirstChoice that he was excluded. Because his exclusion resulted from a paperwork error on the part of PGBA, Dr. Thompson could have quickly remedied this situation. Instead, his applications were approved and he was issued a provider number. In addition, through the U.S. Attorney's Office, the Government has already investigated this matter and determined that no repayment was necessary.

In addition to the fact that the previous actions by the Government should estop it from instituting this overpayment collection proceeding, it also documents that FirstChoice was without fault and therefore, collection of this overpayment should be waived. Dr. Thompson was approved as a Medicare provider by CMS and was issued a provider number. As outlined above, Dr. Thompson and FirstChoice relied on CMS when it billed for Dr. Thompson's services. Had CMS, PGBA or any other

Palmetto GBA
June 15, 2007
Page 4

entity informed Dr. Thompson or FirstChoice that Dr. Thompson was listed as an excluded provider, they would have remedied the technical error and this matter would have never arisen.

As an additional matter, you will note that the overpayment demand is for \$101,650.14. The Claims Review Worksheet attached to the Overpayment Letter only notes payments for \$53,860.01. We cannot reconcile these amounts and do not understand how the \$101,650.14 was determined.

The reason for Dr. Thompson's sanction was not related to any healthcare fraud. At all times Dr. Thompson was a licensed physician in good standing while providing covered services to the Medicare beneficiaries. All services provided were medically necessary and have not been objected to otherwise. Therefore, we believe this overpayment demand is in error and should be reversed.

Objection to Withhold

In the Overpayment Letter, it states that PGBA will withhold payments to FirstChoice if the overpayment is not paid in full by June 28, 2007. It further states FirstChoice may notify PGBA within fifteen days (15) from the date of the Overpayment Letter. Today, June 14 is the fifteenth day. Pursuant to the Overpayment Letter and 42 C.F.R. 405.374, we request that no future Medicare funds be withheld based on the substantive arguments outlined above.

We spoke to representatives with Medicare Part B Accounts Receivable and Appeals regarding this matter as well. They stated that if a request for redetermination was received prior to the withhold date in the Overpayment Letter, no withhold would be implemented. Further, because we feel this overpayment demand is in error and are appealing it pursuant to this letter, it would be inequitable to withhold payments to FirstChoice until a final determination is made.

Should you have any questions, or need any further information, please contact me.

Sincerely,


Wes Jackson



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

June 11, 2007

FirstChoice Healthcare PC
1920 Second Loop Road
Florence, SC 29501-6123

RE: Overpayment amount of \$101,650.14
Accounts Receivable Number: 88000010025757

Dear Provider:

This letter is in reference to the letter you received dated 05/30/2007. The incorrect dates of services and number of claims were included in the body of the letter. The attachment, however, documented the correct dates of services and number of claims. The correct dates of services are 04/20/00 to 06/20/02 (917 claims). A corrected letter is attached for your records.

We sincerely regret any inconvenience that this may have caused you. If you have any questions, please call (803) 735-1034 Ext.31650

Sincerely,

Louise Custard
Palmetto GBA Part B Accounts Receivable
Enclosure

PAID
JUN 14 2007

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100183 • Columbia, South Carolina • 29202-3183
A CMS Contracted Intermediary and Carrier

Revision: 11/2006 000-000



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

05/30/07

FirstChoice Healthcare PC
1920 Second Loop Road
Florence, SC 29501-6123

RE: Overpayment \$101,650.14
Supplier #: 6672
AR: 88000010025757

Dear Provider:

This is to let you know that you have received Medicare payment in error, which has resulted in an overpayment to you. This letter provides detailed information concerning each claim involved in the overpayment.

TriCenturion, a Program Safeguard Contractor (PSC), completed a review of claims submitted under the above referenced provider / group numbers and paid by Medicare. TriCenturion determined that you received payment in error, resulting in an estimated overpayment to you of \$101,650.14.

It has been determined that Dr. Thompson was sanctioned by the Office of Inspector General from 3/31/96 to 6/20/02, pursuant to § 1128(b)(4) of the Social Security Act, License Revocation or Suspension. TriCenturion's review of claims determined that 917 claims for Medicare payment were submitted while Dr. Thompson was sanctioned. During the sanction period, Part B Medicare claims for dates of service from 04/20/00 - 06/20/02 were paid to you. Please reference the enclosed worksheet that provides a listing of the claims. Along with our claim payment determinations, we made limitation of liability decisions for the denial of the services subject to the provisions of §1879 of the Social Security Act.

Section 1870 of the Social Security Act 42 CFR 405.350-359 permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. We have made the determination that you were "with fault" in causing or accepting the payment.

If you disagree with this overpayment decision you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter.

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100183 • Columbia, South Carolina • 29202-3183
A CMS Contracted Intermediary and Carrier

Form CMS-723-10 Revised First Denial Letter
Rev. 01/01 01-07-06
Page 1 of 3

635



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

Medicare Part B Appeals
P.O. Box 100190
Columbia, SC 29202-3190

Please understand that a request for a redetermination will not alter the overpayment request until a final decision has been determined as to whether the overpayment is affirmed or withdrawn. Should the appealed decision be in your favor, our office will refund any money collected from you.

Please send a check in the amount of \$ 101,650.14 with a copy of this letter in the enclosed pre-addressed envelope by 06/28/2007:

Medicare Part B
PO Box 100183
Columbia, SC 29202-3183

For overnight delivery please make check out to Medicare Part B, but send to:

Palmetto GBA-Part B Accounts Receivable (AG-342)
2300 Springdale Drive
Building One
Camden, South Carolina 29020

In accordance with 42 CFR 405.378 simple interest at the rate of 12.375 % will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30 day period that payment is not made on time. Thus if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. See enclosure for details. Any repayment plan, where one is approved, would run from the date of this letter.

If payment in full is not received by 6/28/07, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur on 07/08/07 you must notify Palmetto GBA within 15 days from the date of this

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3190

A CMS Contracted Intermediary and Carrier



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

notice. We will review your documentation, but will not delay the recoupment. This is not an appeal of the overpayment determination.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy petition please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If this payment has already been refunded to our office for provider 6672, please complete the following information and return this letter to us in the enclosed envelope.

Check Number: _____
Check Date: _____
Check Amount: _____

Questions regarding the payment of this overpayment may be directed to (803) 735-1034, extension 31643.

Sincerely,

Mary Littlejohn
Palmetto GBA Part B Accounts Receivable
Enclosure

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3190

A CMS Contracted Intermediary and Carrier



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

05/30/07

FirstChoice Healthcare PC
1920 Second Loop Road
Florence, SC 29501-6123

RE: Overpayment \$101,650.14
Supplier #: 6672
AR: 88000010025757

Dear Provider:

This is to let you know that you have received Medicare payment in error, which has resulted in an overpayment to you. This letter provides detailed information concerning each claim involved in the overpayment.

TriCenturion, a Program Safeguard Contractor (PSC), completed a review of claims submitted under the above referenced provider / group numbers and paid by Medicare. TriCenturion determined that you received payment in error, resulting in an estimated overpayment to you of \$101,650.14.

It has been determined that Dr. Thompson was sanctioned by the Office of Inspector General from 3/31/96 to 6/20/02, pursuant to § 1128(b)(4) of the Social Security Act, License Revocation or Suspension. TriCenturion's review of claims determined that 3 claims for Medicare payment were submitted while Dr. Thompson was sanctioned. During the sanction period, Part B Medicare claims for dates of service from 10/11/01 - 12/10/01 were paid to you. Please reference the enclosed worksheet that provides a listing of the claims. Along with our claim payment determinations, we made limitation of liability decisions for the denial of the services subject to the provisions of §1879 of the Social Security Act.

Section 1870 of the Social Security Act 42 CFR 405.350-359 permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. We have made the determination that you were "with fault" in causing or accepting the payment.

If you disagree with this overpayment decision you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter.

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100180 • Columbia, South Carolina • 29202-3183
A CMS Contracted Intermediary and Carrier

FA-CSP-72-148 Internal Use Document Only
Revised 2/96/04
Page 1 of 1



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

Medicare Part B Appeals
P.O. Box 100190
Columbia, SC 29202-3190

Please understand that a request for a redetermination will not alter the overpayment request until a final decision has been determined as to whether the overpayment is affirmed or withdrawn. Should the appealed decision be in your favor, our office will refund any money collected from you.

Please send a check in the amount of \$ 101,650.14 with a copy of this letter in the enclosed pre-addressed envelope by 06/28/2007:

Medicare Part B
PO Box 100183
Columbia, SC 29202-3183

For overnight delivery please make check out to Medicare Part B, but send to:

Palmetto GBA-Part B Accounts Receivable (AG-342)
2300 Springdale Drive
Building One
Camden, South Carolina 29020

In accordance with 42 CFR 405.378 simple interest at the rate of 12.375 % will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30 day period that payment is not made on time. Thus if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. See enclosure for details. Any repayment plan, where one is approved, would run from the date of this letter.

If payment in full is not received by 6/28/07, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur on 07/08/07 you must notify Palmetto GBA within 15 days from the date of this

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100180 • Columbia, South Carolina • 29202-3183
A CMS Contracted Intermediary and Carrier

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Revised 2/96/04
Page 2 of 3

637



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

notice. We will review your documentation, but will not delay the recoupment. This is not an appeal of the overpayment determination.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy petition please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If this payment has already been refunded to our office for provider 6672, please complete the following information and return this letter to us in the enclosed envelope.

Check Number: _____
Check Date: _____
Check Amount: _____

Questions regarding the payment of this overpayment may be directed to (803) 735-1034, extension 31643.

Sincerely,

Mary Littlejohn
Palmetto GBA Part B Accounts Receivable
Enclosure

Palmetto GBA
Medicare Part B Accounts Receivable
Post Office Box 100190 • Columbia, South Carolina • 29202-3183

A CMS Contracted Intermediary and Carrier



TriCenturion
P.O. Box 100222
Columbia, SC 29107-1122

A CMS Program Safeguard Contractor

April 24, 2007

VIA Certified Mail
FirstChoice Healthcare
1920 Second Loop Road
Florence, SC 29501

#: 7005 3110 0002 4046 5400

RE: Review Findings for Dr. Hugh Thompson – Provider # D993216873
FirstChoice Healthcare, 1754 West Carolina Avenue, Hartsville, SC – Group #5873

Dear Sir / Madam:

TriCenturion, a Program Safeguard Contractor (PSC), completed a review of claims submitted under the above referenced provider / group numbers and paid by Medicare. TriCenturion determined that you received payment in error, resulting in an estimated overpayment to you of \$769.64.

It has been determined that Dr. Thompson was sanctioned by the Office of Inspector General from 3/31/96 to 6/20/02, pursuant to § 1128(b)(4) of the Social Security Act, License Revocation or Suspension. TriCenturion's review of claims determined that 3 claims for Medicare payment were submitted while Dr. Thompson was sanctioned. During the sanction period, Part B Medicare claims for dates of service from 10/11/01 – 12/10/01 were paid to you. Please reference the enclosed worksheet that provides a listing of the claims. Along with our claim payment determinations, we made limitation of liability decisions for the denial of the services subject to the provisions of §1879 of the Social Security Act.

Palmetto GBA will be issuing you a demand letter for the above overpayment and notifying you of your rebuttal and appeal rights.

If you have any questions regarding this matter, you may contact me at (803) 264-8145.

Sincerely,

Althea B. Myers, AHFI
Senior Investigator
Integrated Benefit Management Team

Enclosures
Claims Review Worksheet

QSF 8047
Revision Level 0
Revision Date 03/21/06



TriCenturion
P.O. Box 100222
Columbia, SC 29107-1122

A CMS Program Safeguard Contractor

April 24, 2007

VIA Certified Mail
FirstChoice Healthcare
1920 2nd Loop Road
Florence, SC 29501

#: 7005 3110 0002 4046 5417

RE: Review Findings for Dr. Hugh Thompson – Provider #D993216672
First Choice Healthcare, 1920 2nd Loop Road, Florence, SC – Group #6672

Dear Sir / Madam:

TriCenturion, a Program Safeguard Contractor (PSC), completed a review of claims submitted under the above referenced provider / group numbers and paid by Medicare. TriCenturion determined that you received payment in error, resulting in an estimated overpayment to you of \$101,650.14.

It has been determined that Dr. Thompson was sanctioned by the Office of Inspector General from 3/31/96 to 6/20/02, pursuant to § 1128(b)(4) of the Social Security Act, License Revocation or Suspension. TriCenturion's review of claims determined that 917 claims for Medicare payment were submitted while Dr. Thompson was sanctioned. During the sanction period, Part B Medicare claims for dates of service from 4/20/00 – 6/20/02 were paid to you. Please reference the enclosed worksheet that provides a listing of the claims. Along with our claim payment determination(s), we made limitation of liability decisions for the denial of the services subject to the provisions of §1879 of the Social Security Act.

Palmetto GBA will be issuing you a demand letter for the above overpayment and notifying you of your rebuttal and appeal rights.

If you have any questions regarding this matter, you may contact me at (803) 264-8145.

Sincerely,

Althea B. Myers, AHFI
Senior Investigator
Integrated Benefit Management Team

Enclosures
Claims Review Worksheet

QSF 8047
Revision Level 0
Revision Date 03/21/06



THIS CERTIFICATE MUST BE MAINTAINED IN A READILY RETRIEVABLE MANNER AT ALL TIMES

THOMPSON, HUGH S. MD
FIRST CHOICE HEALTHCARE
1920 SECOND ELM ROAD
FLORENCE, SC 29502

DHEC 1178 (07/2000)

102595-02-N-1540

640

SC Uniform Managed Care Provider Credentialing Application**I. PERSONAL INFORMATION**

☐ Solo Practice or ☒ Group Practice

Name: Last **THOMPSON** First **HUGH** M.I. **S** Suffix ☐ Degree **MD**

Maiden and/or other name:

(List W-9 Name if different)

Place of Birth: (City) **FULTON** (State) **GEORGIA** Date of Birth: **02/10/1940**

If you are not a U.S. Citizen, do you have authorization to work in the U.S.? ☐ Yes ☐ No

☒ Male ☐ Female (OPTIONAL). This information will not be used by the Managed Care Organization in making its determination regarding your participation.

Social Security Number: **251623993** NPI: **1952300196** UPIN Number: **D99321**

Practice Name: **FIRST CHOICE HEALTHCARE, PC**

Tax ID Number: **562008691** Group NPI: **1912001264**

E-mail address of practitioner:

II. MEDICAL LICENSE/REGISTRATION

- A. If you are a family practitioner, do you offer OB care? ☐ Yes ☒ No
- B. Do you speak any foreign language fluently that you would like added to the directory? ☐ Yes ☒ No

If yes, please specify:

- C. ECFMG Number:
-

Current Professional License Number(s) (Indicate if not applicable):

NA ☐1. SC Medical License Number: **MD7087** Issue Date: **10/1980** Expiration Date: **09/30/2009**

2. Additional Medical State Licenses and Numbers:

State:	License Number:	Issue Date:	Expiration Date:
State:	License Number:	Issue Date:	Expiration Date:
State:	License Number:	Issue Date:	Expiration Date:

3. DEA No.: **BT6370403** Expiration Date: **11/30/2010** SC Cont. Drug Perm. No.: **20-07087** Expiration Date: **10/01/2008**

History of Previous Licensure in all Jurisdictions (Indicate if not applicable):

NA ☒

State:	License Number:	Issue Date:	Expiration Date:
State:	License Number:	Issue Date:	Expiration Date:
State:	License Number:	Issue Date:	Expiration Date:

III. EDUCATION/TRAINING/HOSPITAL PRIVILEGES

1. Medical School Institution: **MEDICAL UNIVERSITY OF SOUTH CAROLINA**

City: **CHARLESTON** State: **SC** Country: **USA**

Date of Entry: **09/1987** Graduation Date (MMYY): **09/1973** Degree: **MD**

Internship Institution: **MUSC TEACHING HOSPITAL** Specialty:

City: **CHARLESTON** State: **SC** Country: **USA**

Program Completed: ☒ Yes ☐ No Date of Entry (MMYY): **1971** Completion Date (MMYY): **1974**

Residency Institution: **DUKE MEDICAL SCHOOL** Specialty: **ANESTHESIOLOGY**

City: **DURHAM** State: **NC** Country: **USA**

Program Completed: ☒ Yes ☐ No Date of Entry (MMYY): **07/1974** Completion Date (MMYY): **09/1976**

Fellowship Institution: Specialty:

City: State: Country:

Program Completed: ☐ Yes ☐ No Date of Entry (MMYY): Completion Date (MMYY):

2. CME REQUIREMENTS:

Number of CME credits completed in the last two years:

3. HOSPITAL STAFF PRIVILEGES

Name: **SEE ACCOMPANYING LETTER**

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

If you do not admit please describe arrangements to provide hospital care:

Provider Initials: Date:

IV. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES		CERTIFYING BOARD	DATE CERTIFIED	EXPIRATION DATE
Primary	ANESTHESIOLOGY	AMERICAN BOARD OF ANTHESIOLOGY	10/1980	N/A
If not Board certified, do you plan to take certifying exam? ☐ Yes, Date ☐ No				
Secondary	ANESTHESIOLOGY	AMERICAN COLLEGE OF ANESTHESIOLOGY		
If not Board certified, do you plan to take certifying exam? ☐ Yes, Date ☐ No				

Under which specialty do you wish to be listed in the Directory? **ANESTHESIOLOGY/PAIN MEDICINE**

Are you applying for participation as:

Primary Care Physician: ☐ Specialist: ☒ Non-Physician Practitioner: ☐

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please attach a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE
THE MEDICAL PROTECTIVE COMPANY	19840	04/14/2006	04/14/2008	\$1,000,000.00/\$3,000,000.00
JOINT UNDERWRITING ASSOCIATION	JB021206	07/24/2002	04/14/2006	\$200,000.00/\$600,000.00
PATIENTS COMPENSATION FUND	83312	05/18/2003	04/14/2006	\$1,000,000.00/\$3,000,000.00

VI. Five Year Work History *(CV can not be used in lieu of completing this section)*

NAME OF PREVIOUS/CURRENT EMPLOYER(S)

DATE OF EMPLOYMENT
(MM/DD/YY-MM/DD/YY)

1.	First Choice Health Care, PC	1998-present
2.	Advanced Medical Associates	1999-2001
3.	Pee Dee Health Care, PA	1999-2000
4.	Fowler Rural Medical Center	1998-1999
5.		

Please provide an explanation of any gaps in employment: **n/a**

Signature:

Date:

RUBBER STAMPED AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

Please print name: **HUGH S. THOMPSON, MD**

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS**(This section must be completed by practitioner)**

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. *(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

- | | |
|---|--|
| 1. Do you have any pending misdemeanor or felony charges? | ☐ Yes ☒ No |
| 2. Have you ever been convicted of a felony? | ☐ Yes ☒ No |
| 3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? | ☐ Yes ☒ No |
| 4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | ☐ Yes ☒ No |
| 5. Considering the essential functions of a practitioner in your area of practice, in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? | ☐ Yes ☒ No |
| 6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board? | ☒ Yes ☒ No |
| 7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? | ☒ Yes ☐ No |
| 8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited? | ☐ Yes ☒ No |
| 9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs? | ☒ Yes ☐ No |
| 10. Has your participation in an Insurance Company network ever been limited or terminated? | ☐ Yes ☒ No |
| 11. In the past five years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? | ☐ Yes ☒ No |
| 12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? | ☐ Yes ☒ No |
| 13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you? | ☒ Yes ☐ No |
| 14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage? | ☐ Yes ☒ No |

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

- A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
- B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;
- C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;
- D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME:

HUGH S. THOMPSON, MD

(print or type)

SIGNATURE:

(Applicant)

DATE:

Must be signed in ink

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Rubber Stamped and Electronic Signatures Are Not Acceptable

**Practitioners have the right to review information obtained to evaluate their
credentialing and recredentialing applications.**

SC Uniform Managed Care Office Information**I. GENERAL INFORMATION**

- A. Do you accept Medicaid patients? ☒ Yes Medicaid ID number: **070871** No ☐
- B. Have you signed an agreement to participate with Medicare in the past twelve months? ☒ Yes Medicare Group ID number: **D993321** No ☐
- C. Are you accepting new patients? ☒ Yes No ☐
- D. Are there any age limitations? ☒ Yes, Minimum Age: **18** Maximum Age: No ☐
- E. Are there gender restrictions? Males Only ☐ Females Only ☐ Both/ no restrictions ☐

Please describe any other patient limitations:

II. OFFICE INFORMATION

- A. Office Address: (physical) **1920 SECOND LOOP RD**
1. Practice Name: **First Choice Health Care, PC** EIN#: **56-2008691**
2. Street: **1920 SECOND LOOP RD** City: **FLORENCE** County: **FLORENCE** State: **SC** (Zip) **29501**
3. Appointment Phone: **843-678-9777** Fax: **843-665-2814**
4. Office Contact Person: **STEPHANIE HARRINGTON**
5. Credentialing Contact Phone Number: **843-678-9777 EXT 111**
6. List of all practitioners (including physician extenders) who are at this location. Indicate (P) for Participating and (A) for applying by each name: If need more room, attach a separate sheet.

Status	Practitioner
A	LISA M MANCUSO, MD
A	GEORGE A BITTING, MD
A	STEPHEN E. BOATWRIGHT, MD

7. Do you offer 24-hour/7-day coverage? ☒ Yes ☐ No Please describe: **ANSWERING SERVICE/ON CALL DR IS PAGED**
8. List physicians who are not a part of your practice with whom you share call:
9. What hours are you available to see patients in this office:
- | | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---------|----------------|----------------|----------------|----------|--------|----------|--------|
| From/To | 8AM-5PM | 8AM-5PM | 8AM-5PM | | | | |
10. After hours phone number: **843-678-9777**
11. Is your office equipped with telecommunications devices for the deaf (TDD): ☐ Yes ☒ No
12. Sign language assistance available: ☒ Yes ☐ No
13. Languages spoken by office staff: **SPANISH**
14. Handicap Access: ☒ Yes ☐ No

B. Billing Address: (if different)

1. Name claims payable to:

2. Street/PO:

City:

State:

Zip:

3. Phone:

Fax:

C. Mailing Address: (if different)

1. Street/PO:

City:

State:

Zip:

2. Phone:

Fax:

D. Office e-mail address (if any):**E. Practice Web site address (if any):**

ATTACHMENT -FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE

A. Satellite Office Address (physical):

1. Practice Name: EIN#:
2. Street: City: County: State: Zip:
3. Phone: Fax:
4. Office Contact Person:
5. Credentialing Contact Phone Number:
6. List of practitioners (including physician extenders) who are billing at this location. Indicate (P) for Participating and (A) for applying by each name. If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Please describe:

8. List physicians who are not a part of your practice with whom you share call:

9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number:
11. Is your office equipped with telecommunications devices for the deaf (TDD): ☐ Yes ☐ No
12. Sign language assistance available: ☐ Yes ☐ No
13. Languages spoken by office staff:
14. Handicap Access: ☐ Yes ☐ No

B. Billing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

C. Mailing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

- D. Office e-mail address:

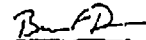
- E. Practice Web site address (if any):

State of South Carolina
Department of Labor, Licensing and Regulation
Board of Medical Examiners

HUGH SMITH THOMPSON, M.D.

Is Authorized to Practice as a
Medical Physician

License Number: MD 7087
Expires: 09/30/2009


Administrator

The following are explanations to the boxes checked yes on the Managed Care Organization liability information portion of the South Carolina Uniform Managed Care Provider Credentialing Application.

To question 3 that states, *"Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, suspended, challenged, revoked, conditioned or otherwise limited?"*

Sanctioned by SC Board of Medical Examiners for prescribing violation (one patient involved); License suspended pending payment of fine-final order, May, 1994.

Question No. 4: *"In the past five years and up to and including the present, have you any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?"*

Voluntarily sought treatment for alcohol abuse, completed successfully. Participating in SC Recovering Professionals Program, in complete compliance with all requirements, including monitoring

Question No. 6: *"Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?"*

Same answer as that for #3

Question No. 7: *"Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquish or otherwise limited?"*

**Controlled drug certification limited by final order of May 1994 to "Institutional only".
Now restored to no restrictions.**

Question No. 11: *"In the past five years and up to the present, have you have a history of chemical dependency or substance abuse that might affect your ability to completely and safely perform the essential functions of the practitioner in your area of practice?"*

Same answer to question #5.

Question No. 13: *"Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of medical malpractice claim on your behalf or any medical malpractice suits pending against you?"*

Two settlements in: 1986 and 1989 or '90. Both cases with multiple defendants arising out of surgical cases in hospital.

Hugh S. Thompson, M.D.

CAROLINAS MEDICAL ALLIANCE HOSPITALISTS

Troy B. Gamble, Jr., M.D., Director
Jorge F. Velazco, M.D.

William H. Woodberry, M.D.
Cassandra Sisk, PA-C

January 22, 2007

To Whom It May Concern:

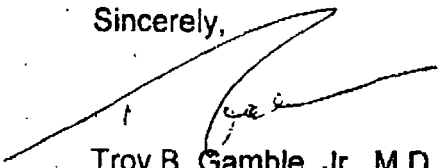
RE: Physicians of First Choice Health Care

We have agreed to admit patients for the physicians of First Choice Healthcare. As Hospitalists at Carolinas Hospital System, we will admit and provide inpatient care to patients requiring inpatient treatment when referred by the following physicians:

Dr. Wendy Miller
Dr. Woody Dixon
Dr. Hugh Thompson
Dr. Lisa Mancuso
Dr. George Bitting
Dr. Stephen Boatwright
Dr. Michelle Scott
Mrs. Carol Ann Berry, APRN
Mrs. Deborah Hopla, APRN

If you have other questions, please do not hesitate to contact me.

Sincerely,



Troy B. Gamble, Jr., M.D.

CERTIFICATE OF REGISTRATION
ISSUED PURSUANT TO THE
SOUTH CAROLINA CONTROLLED SUBSTANCES ACT
THIS CERTIFICATE MUST BE MAINTAINED IN A READILY RETRIEVABLE MANNER AT ALL TIMES.

DC63540 -9	DATE OF ISSUE	REGISTRATION FEE	CODE	EXPIRATION DATE
	07/25/2007	125.00		10/01/2008
SCHEDULES OF CONTROLLED SUBSTANCES AUTHORIZED*	DEA REGISTRATION NUMBER	STATE REGISTRATION NUMBER		
22N33N45	BT6370403	20-07087		

THOMPSON, HUGH S., MD
FIRST CHOICE HEALTHCARE
1920 SECOND LOOP ROAD
FLORENCE SC 29501

*2-II-NARCOTIC; 2N-II-NON-NARCOTIC; 3-III-NARCOTIC; 3N-III-NON-NARCOTIC; 4-SCHEDULE IV-ALL; 5-SCHEDULE V-ALL

THIS CERTIFICATE IS NOT TRANSFERABLE UPON CHANGE OF OWNERSHIP OR ADDRESS

S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

BUREAU OF DRUG CONTROL

2600 BULL STREET

COLUMBIA, SOUTH CAROLINA 29201

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

THOMPSON, HUGH S MD
1920 SECOND LOOP RD
2011C SEOND LOOP ROAD
FLORENCE, SC 29501-0000

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY,
AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CERTIFICATE OF INSURANCE

Issue Date:

03/23/07

NAMED INSURED:

Hugh Thompson, MD
Firstchoice Healthcare
1920 Second Loop Rd
Florence, SC 29501

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION
ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER.
THIS CERTIFICATE DOES NOT AMEND, EXTEND, OR ALTER THE
COVERAGE AFFORDED BY THE POLICY DESCRIBED BELOW.

PRODUCING AGENCY:

Professional Liability Solutions, LLC
7421 Carmel Executive Park Suite 226
Charlotte, NC 28226
(704) 927-5980

COVERAGE PROVIDED BY:

The Medical Protective Company
5814 Reed Road, PO Box 15021
Fort Wayne, IN 46385

COVERAGES

This is to certify that the policy of insurance listed below has been issued to the insured named above for the policy period indicated. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policy described herein is subject to all the terms, exclusions, and conditions of such policy. Limits shown may have been reduced by paid claims.

Your professional liability insurance provides coverage for claims made during the effective period, based on professional services rendered or which should have been rendered during the effective period of this policy. If your policy is written on **CLAIMS-MADE** basis, coverage is provided for claims made during the effective period, based on professional services rendered or which should have been rendered on or after the retroactive date. Also, if, your policy is a claims-made form, no coverage exists for claims first made against you after the end of the policy period unless, and to the extent, an extended reporting endorsement is obtained.

POLICY COVERAGE:	Medical Professional Liability
POLICY TYPE:	Claims-Made
POLICY NUMBER:	713500
SPECIALTY:	Anesthesiology
RETROACTIVE DATE:	04/14/06
POLICY EFFECTIVE DATE:	04/14/07
POLICY EXPIRATION DATE:	04/14/08
PER CLAIM LIABILITY:	\$1,000,000
ANNUAL AGGREGATE:	\$3,000,000
SPECIAL CONDITIONS:	

The above Insured is:

☒ Named Insured ☐ Additional Insured
☐ Locum Tenens ☐ Additional Named Insured

CERTIFICATE HOLDER:**CANCELLATION:**

Should the above described policy be cancelled before the expiration date thereof, the issuing company is under no obligation or liability of any kind to notify the certificate holder.

Photocopies of the certificate of insurance are deemed as valid as the original.

AUTHORIZED REPRESENTATIVE:
O. Wagner, Pres., Agent

Curriculum Vitae

Hugh S. Thompson M.D.

Born: 02/10/1940
Social Security number: 251-62-3993
South Carolina Medical License # 7087

DEA Registration # BT6370403
Schedules of Control Substances Authorization # 22N33N45
State Registration Controlled Substances # 20-07087

SC Medicare # D99321
SC Medicaid # 070871

Education:

Undergraduate School: Citadel

B.S. Pharmacy, Medical University of South Carolina, 1967
Rho Chi pharmaceutical honor society
Eli Lilly Pharmacognosy Award

Medical Degree, Medical University of South Carolina, graduated 1973
Alpha Omega Alpha medical honor society

Surgical Internship, Medical University of South Carolina Teaching Hospitals, completed 1974

Residency in Anesthesiologist, Duke University Medical Center, completed 1976
Chief Resident 1976
Board certified Anesthesiologist, 1980
American Board of Anesthesiologist, 1980
Fellow American College of Anesthesiologist #8283, 1979

Research Information:

Participated in research activities involving pharmacology (chemotherapy of neoplasia).
Diving and hyperbaric physiology and medicine of extreme environments.

Work History:

Firstchoice Healthcare PC 1998-present
Advanced Medical Associates 1999-present
Medical Neurological Services 2001-present
Pee Dee Healthcare P.A. 1998-2000
Fowler Rural Medical Center, May-October 1998
Hugh S. Thompson M.D. P.A. 1986-1994
Pee Dee Anesthesia Associates P.A. 1977-1986
Craven County Hospital, New Bern N.C. 1976-1977

There is a five-year gap in my work history in which I voluntarily left the practice of medicine to pursue another career in a different field. I returned to medicine in 1998.

Other Achievements:

Served United States Marine Corps, enlisted, amphibious infantry, honorably discharged 1962.

Associations:

American Society of Anesthesiology

American Academy of Pain Management

References:

L. Thomas Barnett M.D.

305 E Cheves St

Florence South Carolina 29501

Phone: 843-662-1533

Dewey N. Ervin M.D.

901 E Cheves St

Florence South Carolina 29501

Phone: 843-662-5233

Michael Kielar M.D.

2204 Timberlake Dr.

Florence South Carolina 29506

Phone: 843-662-1729

Josiah S. Matthews M.D.

201 Cashua St

Darlington South Carolina

Phone: 843-393-7452

Hugh S. Thompson, M.D.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

FIRSTCHOICE HEALTHCARE PC
2011-C SECOND LOOP ROAD
FLORENCE, SC 29501

LABORATORY DIRECTOR

WENDY L MILLER MD

CLIA ID NUMBER

42D1002367

EFFECTIVE DATE

08/06/2006

EXPIRATION DATE

08/05/2008

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

317 cert1_070806

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.

State of South Carolina
Department of Labor, Licensing and Regulation
Board of Medical Examiners

HUGH SMITH THOMPSON, M.D.

Is Authorized to Practice as a
Medical Physician



License Number: MD 7087
Expires: 09/30/2009


Administrator



Date: Monday, July 23, 2007

To: Pawnee Kenimer
Company: FirstChoice HealthCare, PC
Phone #:
Fax#: 843-665-2814

From:
Company: MedCost, LLC.
Phone #:
Fax#:

Number of pages including coversheet: 01

Comments: To notify you that Hugh S Thompson, MD's re-credentialing is complete.

For Your Health Matters
165 Kimmel Park Drive, Winston Salem, NC 27103
800-433-9178 www.medcost.com

WARNING: Any medical information contained in this fax message is CONFIDENTIAL and privileged. It is unlawful for unauthorized persons to view, copy, disclose, or disseminate CONFIDENTIAL information. The following information is CONFIDENTIAL AND PRIVILEGED and intended for the sole use of the addressee. If the reader of this facsimile is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify the person listed above and return the original message to the sender at the address listed above. Please call if the message you received was incomplete or illegible.



AMA Profile Service Credentialing Newsletter Sample Profiles

Thank You

Hugh Thompson

- ▶ [My Account](#)
- ▶ [Account Activity](#)
- ▶ [Order Search](#)
- ▶ [Order Summary](#)
- ▶ [Searching Tips](#)
- ▶ [Help](#)
- ▶ [Logout](#)

Customer Service:
800-665-2882
8:30 am - 4:45 pm CST
Monday - Friday

Dear Dr. banks:

Thank you for your AMA Profile order. Your Profile will be delivered to North Carolina Medical Board.

Your order number is: **3480082**

You may contact the AMA Unified Service Center at 800-621-8335 if you have specific questions about your order. Representatives are available to assist you Monday-Friday, 8:30am - 4:45pm CST.

We are pleased to have this opportunity to serve you and support you with your credentialing needs.

[Place Another Order](#) [Logout](#)

In today's increasingly digital world, the opportunity to control access to your prescribing data is invaluable. That's why the AMA created the Physician Data Restriction Program (PDRP). This program is intended to put the control in your hands and let you make the decision. [Click here](#) for more details on how to make the choice.

Privacy Statement

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AMA physician profile

* Copy of Profile
Attached *

Ph# 800-621-8335

Copy of profile is free to Dr

if medical board needs it, NC medical board
will only accept the profile from the AMA.

cost to forward is \$31.00 for non-member
free for members

yearly membership to AMA is \$420.00



AMA Physician Profile Self Inquiry

This information represents the most current information available and is for identification purposes only. You must submit an order to receive an official AMA Physician Profile to meet the Joint Commission, NCQA, and American Accreditation Healthcare Commission/URAC credentialing standards.

Please take a few minutes to review and update your profile. If there are changes or additions to the information below, please update this form and return it to the American Medical Association, Division of Survey and Data Resources. At the above address.

Please provide the following information so we may contact you if there are any questions.

PHONE: _____ ☐ Home ☐ Office
FAX: _____ ☐ Home ☐ Office
E-MAIL: _____ ☐ Home ☐ Office

★★

Name and Mailing Address:

ME Number: 04501731311
HUGH SMITH THOMPSON MD
1920 2ND LOOP RD
FLORENCE SC 29501-6123

Primary Office Address:

SAME AS MAILING ADDRESS

Birthdate: 02/10/1940 Phone: UNKNOWN
Birthplace: ATLANTA, GA UNITED STATES OF AMERICA Fax: 1-843-665-2814
E-mail: STEPHANH@SC.RR.COM

Any type of legal/official change to name (i.e. marriage, divorce, citizenship, etc.), birth date, or birth place requires legal documentation.

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Choose one of the following:

____ Resident ____ Research ____ Administration
____ Office Based Solo ____ Office Based Group ____ Office Based HMO



AMA Physician Profile Self Inquiry

☐ Full-Time Hospital Staff ☐ Medical Teaching ☐ Inactive

Practice Specialties Self Designated by the Physician*:

Primary Specialty: ANESTHESIOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

_____ All Information from this Point Forward is Provided by the Primary Source _____

Current and/or Historical Medical School:

MED UNIV OF SC COLL OF MED, CHARLESTON SC 29425

Degree Awarded: Yes

Degree Year: 1973

Changes require a copy of the degree from the graduating medical school.



AMA Physician Profile Self Inquiry

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: MED UNIV SC MED CTR
Specialty : GENERAL SURGERY

State: SOUTH CAROLINA
07/1973 - 06/1974
(VERIFIED)

Institution: DUKE UNIV MED CTR
Specialty : ANESTHESIOLOGY

State: NORTH CAROLINA
07/1974 - 09/1974
(VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Please provide a copy of the document from the issuing program institution. Note: Foreign training or non-ACGME accredited program information are neither collected nor maintained in the AMA Physician Masterfile.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1974

Current and/or Historical Medical Licensure:

<u>Jurisdiction</u>	<u>MD/ DO</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Status</u>	<u>License Type</u>	<u>Last Reported</u>
NORTH CAROLINA	MD	01/01/1976	NOT RPTD	INACTIVE	UNLIMITED	06/16/2003



AMA Physician Profile Self Inquiry

Current and/or Historical Medical Licensure:

<u>Jurisdiction</u>	<u>MD/ DO</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Status</u>	<u>License Type</u>	<u>Last Reported</u>
SOUTH CAROLINA	MD	07/01/1974	09/30/2009	ACTIVE	UNLIMITED	12/27/2007

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

Please p

_____	_____ MD _____ DO
_____	_____ MD _____ DO
_____	_____ MD _____ DO
_____	_____ MD _____ DO

ECFMG Certification:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

* Only the last three characters of active DEA number(s) are displayed.

<u>DEA Number *</u>	<u>Schedule</u>	<u>Expiration Date</u>	<u>Last Reported</u>
XXXXXX403	22N 33N 4 5	11/30/2010	01/09/2008

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.



AMA Physician Profile Self Inquiry

Please provide your federal DEA registration number and expiration date (mm/dd/yyyy format):

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF ANESTHESIOLOGY

Certificate: ANESTHESIOLOGY

Certificate Type: GENERAL

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Occurrence</u>	<u>Last Reported</u>
LIFETIME	10/03/1980		INITIAL	01/11/2008

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2008 American Board of Medical Specialties. All right reserved.



AMA Physician Profile Self Inquiry

Medicare/Medicaid Sanction(s):

THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), IN RELATION TO MEDICARE AND MEDICAID REGULATIONS, HAS TAKEN AN ACTION. FOR ACTION DETAILS OR CONTACT INFORMATION, PLEASE REFER TO THE DHHS WEB SITE AT <http://oig.hhs.gov/>.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (<http://www.ama-assn.org/go/amaprofiles>) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800-665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

Physician Data Restriction Program

In today's increasingly digital world, the opportunity to control access to your prescribing data is invaluable. That's why the AMA established the Physician Data Restriction Program. This program is intended to put the control in your hands and let you make the decision. Visit www.ama-assn.org/go/prescribingdata on the AMA's Web Site for more details on how to make the choice.

699

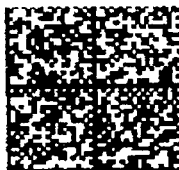
INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.

This is our method of acknowledging receipt of your application.

**PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO
ENSURE DELIVERY BY THE POST OFFICE.**

**Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501**



HASLER

\$0.42

OCT 08 2008

PLACE STAMP
HERE FIRST-CLASS
OFFICE MAIL
MAIL ROOM 27607
ATTN: 1300 373
POSTAGE

Hugh S. Thompson, MD
Name

1920 Second Loop Rd
Address

Florence, SC 29501
City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

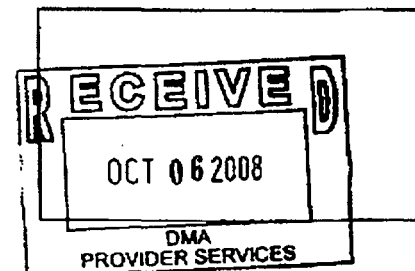
We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services



June 4, 2008

Hugh S. Thompson MD
First Choice Healthcare PC
1920 Second Loop Road
Florence, SC 29501

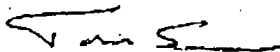
Dear Dr. Thompson:

Welcome to the Select Health of South Carolina, Inc. network of providers. Since 1996, Select Health has been providing quality, accessible healthcare to the citizens of South Carolina through our First Choice plan.

The effective date of your appointment to our provider network is May 14, 2008. Your specialty will be listed as Anesthesiology. Your provider number is 20004955. Please submit this unique provider number on all claims and correspondence. Your inquiry will be expedited if you refer to this number when calling the Plan. I have attached a copy of the executed Physician Participation Agreement for your files. If your practice has not already received an orientation, your Network Management Representative will be calling soon to arrange one. If you have a question in the meantime, please call our Network Management Department at 1-800-741-6605.

We are very pleased that plan members may now have access to the outstanding services provided by your practice.

Sincerely,



Tom Sommer
Manager, Network Management

**Amendment to Select Health of South Carolina, Inc.
Provider Participation**

THIS AMENDMENT TO THE PHYSICIAN PARTICIPATION AGREEMENT is made this ____ day of _____, 20____ by and between SELECT HEALTH OF SOUTH CAROLINA, INC. (hereinafter referred to as PLAN) and Hugh S. Thompson, MD (hereinafter referred to as PROVIDER.)

WHEREAS PLAN and PROVIDER have duly executed a Physician Participation Agreement (hereinafter AGREEMENT) pursuant to which PROVIDER became obligated to provide certain services to PLAN Members and;

WHEREAS, PLAN desires to amend the terms of the AGREEMENT.

PROVIDER hereby guarantees and certifies that each participating physician, dentist or other licensed non-technician medical provider (hereinafter PARTICIPATING PROFESSIONAL) shall abide by all the terms and conditions of the AGREEMENT and shall require each of its PARTICIPATING PROFESSIONALS to acknowledge their obligations under this AGREEMENT by affixing their signature to this AMENDMENT. Under no circumstances shall PROVIDER allow its PARTICIPATING PROFESSIONALS to provide medical services to any PLAN Member without PARTICIPATING PROFESSIONAL acknowledging their obligations by co-executing this Amendment.

Firstchoice Healthcare, PC
Company Name of PROVIDER

[Signature]
PARTICIPATING PROFESSIONAL (Signature)

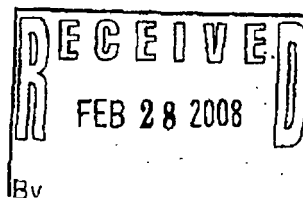
Date 2/17/2008

Hugh S. Thompson, MD
PARTICIPATING PROFESSIONAL (Print or Type)

SELECT HEALTH OF SOUTH CAROLINA, INC.

[Signature]
Signature

Date 6/9/08



Professional Liability Solutions, LLC

7421 Carmel Executive Park Suite 226 ♦ Charlotte, NC 28226
2706 N. Wilton Ave. ♦ Chicago, IL 60614
Local (704) 927-5980 ♦ (800) 372-3268 ♦ Fax (704) 927-5981
www.medmalpractice-ins.com

March 31, 2008

Hugh Thompson, MD
Firstchoice Healthcare
1920 Second Loop Rd
Florence, SC 29501

Dear Dr. Thompson:

Enclosed is your renewal, **Individual Medical Professional Liability** insurance policy underwritten by The Medical Protective Company

Please review all of the policy provisions to verify that they are what you expected and to allow yourself to be familiar with the coverage. Call me immediately if there is anything that you are uncomfortable with or need changed. Below is a brief recap of your coverage.

POLICY COVERAGE:

POLICY TYPE:

POLICY NUMBER:

SPECIALTY:

RETROACTIVE DATE:

POLICY EFFECTIVE DATE:

POLICY EXPIRATION DATE:

PER CLAIM LIABILITY:

ANNUAL AGGREGATE:

SPECIAL CONDITIONS:

Medical Professional Liability

Claims-Made

713500

Anesthesiology

04/14/06

04/14/08

04/14/09

\$1,000,000

\$3,000,000

Please note that higher or lower limits are available, at different premiums and we would be happy to share this information with you; contact our office if you are interested.

I appreciate your business, and you should contact my office for any service needs that you may have concerning this coverage.

Sincerely,

Ottis W. Wagner

CERTIFICATE OF INSURANCE

Issue Date:

03/31/08

NAMED INSURED:

Hugh Thompson, MD
Firstchoice Healthcare PC
1920 Second Loop Rd
Florence, SC 29501

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION
ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER.
THIS CERTIFICATE DOES NOT AMEND, EXTEND, OR ALTER THE
COVERAGE AFFORDED BY THE POLICY DESCRIBED BELOW.

PRODUCING AGENCY:

Professional Liability Solutions, LLC
7421 Carmel Executive Park Suite 226
Charlotte, NC 28226
(704) 927-5980

COVERAGE PROVIDED BY:

The Medical Protective Company
5814 Reed Road, PO Box 15021
Fort Wayne, IN 46385

COVERAGES

This is to certify that the policy of insurance listed below has been issued to the insured named above for the policy period indicated. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policy described herein is subject to all the terms, exclusions, and conditions of such policy. Limits shown may have been reduced by paid claims.

Your professional liability insurance provides coverage for claims made during the effective period, based on professional services rendered or which should have been rendered during the effective period of this policy. If your policy is written on **CLAIMS-MADE** basis, coverage is provided for claims made during the effective period, based on professional services rendered or which should have been rendered on or after the retroactive date. Also, if, your policy is a claims-made form, no coverage exists for claims first made against you after the end of the policy period unless, and to the extent, an extended reporting endorsement is obtained.

POLICY COVERAGE:	Medical Professional Liability
POLICY TYPE:	Claims-Made
POLICY NUMBER:	713500
SPECIALTY:	Anesthesiology
RETROACTIVE DATE:	04/14/06
POLICY EFFECTIVE DATE:	04/14/08
POLICY EXPIRATION DATE:	04/14/09
PER CLAIM LIABILITY:	\$1,000,000
ANNUAL AGGREGATE:	\$3,000,000
SPECIAL CONDITIONS:	

The above Insured is:

☒ Named Insured ☐ Additional Insured
☐ Locum Tenens ☐ Additional Named Insured

CERTIFICATE HOLDER:**CANCELLATION:**

Should the above described policy be cancelled before the expiration date thereof, the issuing company is under no obligation or liability of any kind to notify the certificate holder.

Photocopies of the certificate of insurance are
deemed as valid as the original.

AUTHORIZED REPRESENTATIVE:
O. Wagner, Pres., Agent

SC Uniform Managed Care Provider Credentialing Application**I. PERSONAL INFORMATION**Solo Practice or ☒ Group Practice

Name: (Last): Thompson (First): Hugh (M.I.) S (Suffix) (Degree) MD

Maiden and/or other name:

(List W-9 Name if different)

Place of Birth: (City): Fulton (State): Georgia

Male ☒ Female (OPTIONAL. This information will not be used by the Managed Care Organization in making its determination regarding your participation)

Social Security Number: 251-62-3993

Date of Birth: 02/10/1940

Practice Name: Firstchoice Healthcare PC

Tax ID Number: 56-2008691

UPIN Number: D99321

II. MEDICAL/PROFESSIONAL EDUCATION

A. If you are a family practitioner, do you offer OB care?

☐ Yes ☒ No

B. Do you speak any foreign language fluently that you would like added to the directory?

☐ Yes ☒ No

If yes, please specify: _____

C. ECFMG Number: _____

SPECIALTY	SCHOOL/HOSPITAL	CITY	STATE	FROM/TO (MM/YY- MM/YY)	YEAR COMPLETE	RESIDENCY/DEGREE
Medical/Professional	Medical U. of South Carolina	Charleston	SC	Sept 1967	1973	MD
Internship	Medical U. Of South Carolina Teaching Hospital	Charleston	SC	July	1974	
Residency	Duke Medical School	Durham	NC	July 74-76	1976	
Fellowship						

Professional License Number(s) where currently in practice (Indicate if not applicable):

State: SC DEA No. & Exp. BT6370403 11/30/2004 SC Cont. Drug Perm. No. & Exp. Date 20-07087 10/01/2004

State: _____ DEA No. & Exp. _____ SC Cont. Drug Perm. No. & Exp. Date _____

State: _____ DEA No. & Exp. _____ SC Cont. Drug Perm. No. & Exp. Date _____

III. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES	CERTIFYING BOARD	DATE CERTIFIED	EXPIRATION DATE
Anesthesiology	American Board of Anesthesiology	10/1980	N/A
If not Board certified, do you plan to take certifying exam? ☒ Yes, Date _____ ☐ No			
Anesthesiology	American College of Anesthesiology		N/A
If not Board certified, do you plan to take certifying exam? ☒ Yes, Date _____ ☐ No			

Under which specialty do you wish to be listed in the Directory? Pain Management/ Anesthesiology

IV. HOSPITAL STAFF PRIVILEGES

HOSPITAL NAME	CITY/STATE	STATUS OF PRIVILEGES: (Active, Courtesy, Consulting, etc.)	% OF INPATIENT ADMISSIONS
N/A			

If you do not admit please describe arrangements to provide hospital care:

Dr. Lane Wilner admits to Carolina Hospital System

McLeod Inpatient Physician for McLeod Regional Hospital

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please attach a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE
Joint Underwriting Assoc.	JB021206	7/24/2002	7/24/2004	200,000/600,000
Patient's Compensation Fund	93312	05/18/2003	05/18/2004	1m/3m

VI. Five Year Work History (CV can not be used in lieu of completing this section)

NAME OF PREVIOUS/CURRENT EMPLOYER (S) DATE OF EMPLOYMENT

(MM/DD/YY-MM/DD/YY)

1. Firstchoice Healthcare PC	1998- Present
2. Advanced Medical Associates	1999-2001
3. Pee Dee Health Care PA	1999-2000
4. Fowler Rural Medical Center	1998

Please provide an explanation of any gaps in employment: N/A

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. *(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

1. Do you have any pending misdemeanor or felony charges? ☐ Yes ☒ No
2. Have you ever been convicted of a felony? ☐ Yes ☒ No
3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? ☐ Yes ☒ No
4. In the past five years and up to and including the present, have you any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? ☐ Yes ☒ No
5. Considering the essential functions of a practitioner in your area of practice, in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? ☐ Yes ☒ No
6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board? ☒ Yes ☐ No
7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? ☒ Yes ☐ No
8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited? ☐ Yes ☒ No
9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs? ☒ Yes ☐ No
10. Has your participation in an Insurance Company network ever been limited or terminated? ☐ Yes ☒ No
11. In the past five years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☒ No
12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☒ No
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you? ☒ Yes ☐ No
14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage? ☐ Yes ☒ No

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

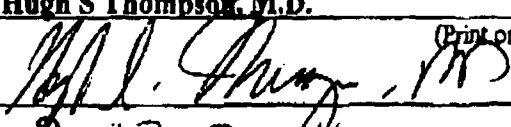
- A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
- B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;
- C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;
- D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME Hugh S Thompson, M.D.

SIGNATURE:  (Print or type)

DATE: 2-12-2004

Must be signed in Ink
EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.
Rubber Stamped Signatures Are Not Acceptable

SC Uniform Managed Care Office Information**I. GENERAL INFORMATION**

- A. Do you accept Medicaid patients? ☒ Yes Medicaid ID number: 070871 ☐ No
- B. Have you signed an agreement to participate with Medicare in the past twelve months? ☒ Yes Medicare ID number: D99321 ☐ No
- C. Are you accepting new patients? ☒ Yes ☐ No
- D. Are there any age limitations? ☒ Yes, specify > 18 years of age ☐ No

Please describe any other patient limitations

II. OFFICE INFORMATION**A. Office Address: (physical)**

1. Practice Name Firstchoice Healthcare PC ETN# 56-2008691
2. Street: 1920 Second Loop Rd City: Florence County: Florence State: SC (Zip) 29501
3. Phone: 843-678-9777 Fax: 843-665-2814
4. Office contact person: Dean Banks (Administrative Director)
5. List of practitioners who are at this location. Indicate (P) for Participating and (A) for applying by each name: If need more room, attach a separate sheet.

Status	Practitioner
P	Dr Kent Vosler
P	Dr William Stamper
A	Dr Lisa Mancuso
P	Dr Andrew Berlowe
	Deborah Hopla, FNP
	Dr William S. Hill

6. Do you offer 24-hour/7-day coverage? ☒ Yes ☐ No Please describe: _____

List physicians who are not a part of your practice with whom you share call: **Dr Lane Wilner, M.D.****Wilner Medical Assoc**
843-665-1280

7.

8. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To	8-12 & 2-6	8-12 & 2-6	8-12 & 2-6	8-12 & 2-6	8-2	Closed	Closed

9. After hours phone number: 843-678-9777

B. Billing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

C. Mailing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

ATTACHMENT - **FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE**

A. Satellite Office Address (physical):

1. Practice Name: Firstchoice Healthcare PC BIN# 56-2008691
2. Street: 754 W. Carolina Ave City: Hartsville County: Darlington State: SC (Zip) 29501
3. Phone: 843-857-0202 Fax: 843-857-0208
4. Office contact person: Rob LaFreniere (Clinic Director)
5. List of practitioners who are billing at this location. Indicate (P) for Participating and (A) for applying by each name:

Status	Practitioner
P	Dr William Stamper
P	Dr Kent Vosler
P	Dr Hugh S Thompson
A	Dr Andrew Berlowe

6. Do you offer 24-hour/7-day coverage? ☒ Yes ☐ No Please describe: _____

7. List physicians who are not a part of your practice with whom you share call: **Dr Emanuel Quayle, MD**

8. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To	8-12 & 2-6	8-12 & 2-6	8-12 & 2-6	8-12 & 2-6	8-2	Closed	Closed

9. After hours phone number: 843-857-0202

B. Billing Address: (if different)

1. Street/PO: 1920 Second Loop Rd City: Florence State: SC Zip: 29501
2. Phone: 843-678-9777 Fax: 843-655-2814

C. Mailing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

ATTACHMENT - **FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE**

The following are explanations to answers marked "Yes" on page 3:

To question #3: *Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?*

And to question #6: *Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?*

Sanctioned by the South Carolina Medical Board for a prescribing violation (one patient involved); License was suspended pending payment of fine. Final order May 1994. My License is now active and unrestricted.

To question #7 *Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?*

Controlled drug certification limited by final order of May 1994 to "Institutional only". Now restored with no limitations.

To question #9: *Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs.*

I left the practice of medicine for several years in the mid 1990s. Since I did not bill Medicare for 4 consecutive months my Medicare number was suspended and made inactive per Medicare policy. I had to reapply for a new number when I returned to Medicine. My participation with Medicare and Medicaid is active and without restrictions currently.

To question # 13: *Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?*

Two malpractice settlements with one in 1986 and one in 1989. Both cases with multiple defendants arising out of surgical cases in hospitals.

In 1986 a young male involved in industrial accident causing fractured femur. Patient underwent surgery for open reduction and internal fixation of the fracture. Uneventful procedure until intramedullary rod insertion when suddenly developed arrhythmia rapidly deteriorating into asystole. Resuscitation with great difficulty. Sent to ICU on mechanical ventilation and never regained consciousness (severe cerebral edema) and expired several days post op.

In 1989 a women in her mid thirties underwent uncomplicated intra-abdominal GYN procedure, spontaneous respirations recovered and moved to recovery room, where she became responsive-had sudden respiratory arrest-I was nearby and successfully resuscitated patient. She regained consciousness and verbalized normally, had normal neurological examination and was breathing spontaneously when discharged from recovery room. Alleged that resuscitation was inadequate, or improperly executed and that she suffered some permanent impairment. Was observed water-skiing sometime after settlement.

I currently have no malpractice suites pending.

Hugh S. Thompson, M.D.

Page 7 of 7

The following are explanations to the boxes checked yes on the Managed Care Organization liability information portion of the South Carolina Uniform Managed Care Provider Credentialing Application.

To question 3 that states, *"Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, suspended, challenged, revoked, conditioned or otherwise limited?"*

Sanctioned by SC Board of Medical Examiners for prescribing violation (one patient involved); License suspended pending payment of fine-final order, May, 1994.

Question No. 4: *"In the past five years and up to and including the present, have you any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?"*

Voluntarily sought treatment for alcohol abuse, completed successfully. Participating in SC Recovering Professionals Program, in complete compliance with all requirements, including monitoring.

Question No. 6: *"Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?"*

Same answer as that for #3

Question No. 7: *"Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquish or otherwise limited?"*

**Controlled drug certification limited by final order of May 1994 to "Institutional only".
Now restored to no restrictions.**

Question No. 11: *"In the past five years and up to the present, have you have a history of chemical dependency or substance abuse that might affect your ability to completely and safely perform the essential functions of the practitioner in your area of practice?"*

Same answer to question #5.

Question No. 13: *"Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of medical malpractice claim on your behalf or any medical malpractice suits pending against you?"*

Two settlements in: 1986 and 1989 or '90. Both cases with multiple defendants arising out of surgical cases in hospital.

Hugh S. Thompson, M.D.

RELEASE OF INFORMATION - (Please read carefully before signing).

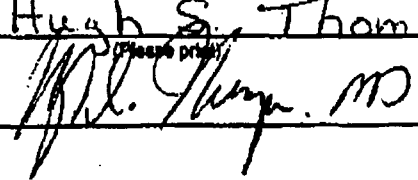
I hereby authorize CIGNA HealthCare of South Carolina, Inc. and its agent to consult with administrators and members of medical staffs of hospitals, facilities or organizations with which I have been associated and with others, including but not limited to past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by CIGNA HealthCare of South Carolina, Inc. and its agents of all records and documents including medical records, held by hospitals, facilities, organizations or others that may be material to an evaluation of my professional qualification and competence to carry out clinical activities as well as my moral and ethical qualifications for membership. I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby release from liability all representative of CIGNA HealthCare of South Carolina, Inc. for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals, organizations or other entities who provide information to CIGNA HealthCare of South Carolina, Inc. in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for participating membership, and I hereby consent to the release of such information.

All information submitted by me to CIGNA HealthCare of South Carolina, Inc. on this application is true and complete to the best of my knowledge.

Date: 2-12-2004

Name: Hugh S. Thompson, MD

Signature: 

Y:\release for



CIGNA HealthCare

BOARD CERTIFICATION CRITERIA FORM

CIGNA HealthCare strongly recommends that a participating physician be Board Certified. Failure to attain Board Certification and maintain continuous Certification may mean that the physician no longer qualifies for continued network participation.

- | | Primary Specialty | Secondary Specialty |
|--|---|--|
| 1. Are you currently Board Certified by a recognized American Specialty Board? <u>If "YES" please send us a copy of your certification (unless already provided.)</u> | YES ☒ NO ☐ | YES ☐ NO ☐ |
| 2. If not certified, have you met all the residency training requirements for certification? | YES ☐ NO ☐ | YES ☐ NO ☐ |
| 3. If not certified, are you actively working towards certification, (ie: are you currently fulfilling the remaining requirements for certification) and/or do you plan to take the certification examination? | YES ☐ NO ☐ | YES ☐ NO ☐ |

If "No," please explain: _____

*****IF YOU DO NOT PLAN TO BECOME BOARD CERTIFIED
PLEASE ATTACH COPIES OF CME CREDITS FOR THE PAST
TWO YEARS*****

- | | | |
|---|--|--|
| 4. When do you anticipate becoming certified? | <u> </u> / <u> </u> / <u> </u>
Mo. Yr. | <u> </u> / <u> </u> / <u> </u>
Mo. Yr. |
| 5. When does your eligibility to sit for the certification examination expire? | <u> </u> / <u> </u> / <u> </u>
Mo. Yr. | <u> </u> / <u> </u> / <u> </u>
Mo. Yr. |
| 6. If you were previously certified in your specialty but did not maintain the certification, please explain why: _____ | | |

I certify that I have read and understand the above statement regarding Board Certification/Recertification, and attest that the information I have provided is complete and accurate to the best of my knowledge.

Signature _____

Date

2-12-2004

Request for taxpayer
Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific instructions on page 2.

Name Hugh S. Thompson	
Business name, if different from above FirstChoice Healthcare, PC	
Check appropriate box: ☐ Individual/ Sole proprietor ☒ Corporation ☐ Partnership ☐ Other ☐ Exempt from backup withholding	
Address (number, street, and apt. or suite no.) 1920 Second Loop Rd.	
City, state, and ZIP code Florence SC 29501	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Social security number								

or

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number										
5	6	2	0	0	8	6	9	1		

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign
Here

Signature of
U.S. person

Date

2-12-2004

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

HOLD HARMLESS AGREEMENT

In accordance with the requirements of Act No. 83 of 1987, and as a condition of participation as a health care provider in CIGNA HealthCare of South Carolina, Inc., the undersigned provider (hereinafter "Provider") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of CIGNA HealthCare of South Carolina, Inc., or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under the enrollees' evidence of coverage. This Agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by, CIGNA HealthCare of South Carolina, Inc. This Agreement further applies in all circumstances including, but not limited to, non-payment by CIGNA HealthCare of South Carolina, Inc., and insolvency of CIGNA HealthCare of South Carolina, Inc. This Agreement shall not prohibit the collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by CIGNA HealthCare of South Carolina, Inc. The Provider further agrees that this Agreement shall be construed to be for the benefit of enrollees of CIGNA HealthCare of South Carolina, Inc., and that this Agreement supersedes any oral or written contrary Agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider: Hugh S. Thompson, MDSignature: [Handwritten Signature]Title: Medical Doctor(Please Type or Print Name & Title): Hugh S. Thompson, MDDate: February 12, 2004

NEXSEN PRUET JACOBS & POLLARD, LLP

ATTORNEYS AND COUNSELORS AT LAW

1441 MAIN STREET, SUITE 1500

POST OFFICE DRAWER 2428

COLUMBIA, SOUTH CAROLINA 29202

HAND DELIVERY

NEXSEN PRUET JACOBS & POLLARD, LLC

ATTORNEYS AND COUNSELORS AT LAW

1441 MAIN STREET, 15TH FLOOR

POST OFFICE DRAWER 2428

COLUMBIA, SOUTH CAROLINA 29202

To:

Ms. Chrissy Lott

Palmetto GBA

17 Technology Circle

Center Parklane Road & Farrow Road

Columbia, SC

General Instructions

The Medicare Federal Health Care Benefit Reassignment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers or suppliers with whom an individual practitioner has a valid reassignment of benefits on file with Medicare, and that the amount of the payments are correct. To accomplish this, Medicare must know basic identifying information about the individual practitioner and the provider/supplier who the individual practitioner is authorizing to receive payment on his or her behalf for services rendered to Medicare beneficiaries.

When completing this application, Medicare must know the name, social security number, and Medicare identification number of the individual practitioner reassigning his or her benefits and the name, tax identification number, Medicare identification number, and practice locations of the supplier receiving the individual practitioner's reassigned benefits.

This application must be completed any time an individual practitioner reassigns his or her benefits to an eligible provider/supplier. Both the individual practitioner and the eligible provider/supplier must be currently enrolled (or concurrently enrolling) in the Medicare program. Generally, this application will be completed by the provider/supplier, signed by the individual practitioner, and submitted by the provider/supplier. When deleting a current reassignment, it is the individual practitioner's responsibility to submit this application with the appropriate sections completed.

This section is to be completed with information as to why this reassignment of benefits application is being submitted.

Reason for Submission of this Application

Check one:

- ☒ Add a New Reassignment
☐ Terminate a Current Reassignment - Effective Date: _____
☐ Add a New Practice Location(s) for a Current Reassignment
☐ Delete a Practice Location(s) from a Current Reassignment
☐ Change Income Reporting Status - Effective Date (MM/DD/YYYY): _____

This section is to be completed with identifying information about the provider/supplier to which the individual practitioner is reassigning his or her benefits.

Legal Business Name of Provider/Supplier as Reported to IRS

Firstchoice Healthcare PC

Tax Identification Number

56-2008691

Medicare Identification Number

6612

This section is to be completed with identifying information about the individual practitioner who will be reassigning (or terminating the reassignment of) his or her benefits to the provider/supplier shown in Section 2 above.

Name First Middle Last Jr., Sr., etc.

Hugh

S.

Thompson

Social Security Number

251-62-3993

Medicare Identification Number

099321

What income reporting form does the individual practitioner receive from the supplier at the end of the calendar year based on his or her relationship with the provider/supplier shown in Section 2?

Check all that apply: ☒ W-2 ☐ 1099 ☐ 1099-K1 Other: _____

SECTION 3: INDIVIDUAL PRACTITIONER IDENTIFICATION

This section is to be completed for each individual practitioner who is reassigning (or terminating reassignment) of his or her Medicare benefits to the provider/supplier shown in Section 2 of this form.

- Furnish the individual's name, social security number, and Medicare identification number.
- Indicate what income reporting form the individual receives from the provider/supplier based on his/her employment with the provider/supplier.

Payroll Agent - If the provider/supplier utilizes an IRS approved Payroll Agent to pay the salaries of W-2 employees reassigning their benefits, the provider/supplier must submit copies of the completed IRS Form 2678 (Employer Appointment of Agent) and the letter (IRS Form 1977C) authorizing the appointment of a payroll agent signed by the IRS Service Center Director. These IRS forms will be used as documentation to establish the employer-employee relationship required under § 3060.1 of the Medicare Carrier Manual.

If the individual practitioner receives a form other than those listed in this section, check "Other" and identify the form.

In situations where a provider/supplier contracts with an organization (e.g., a physician group practice) for physician/practitioner services and there is no direct payment to the physician/practitioner from the provider/supplier, the "Other" block for income reporting should be used and the description should indicate indirect contractual arrangement (ICA).

SECTION 4: PRACTICE LOCATION

This section is to be completed with all practice locations of the provider/supplier identified in Section 2 indicating where the individual practitioner identified in Section 3 will be rendering services on a regular basis.

NOTE: All provider/supplier practice locations reported in this section must have been (or currently are being) reported to the Medicare carrier on the CMS 1550. If a practice location reported in this section has not been previously or currently reported, the reassignment of benefits will be denied.

- A. 1st Practice Location Information - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the attestation statement. Otherwise:
 1. Provide the name of the practice location. If a "doing business as" name is used, provide that name in this section. State the date the individual practitioner began (or will begin) to render services at this location.
 2. Furnish the complete street address for this practice location.
- B-D. 2nd through 4th Practice Locations - These sections are to be used to report additional practice locations where the individual practitioner will render services for the supplier.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are IRS W-2s, pay stubs, or employment contracts.

This section is to be completed with all practice locations of the provider/supplier identified in Section 2 indicating where the individual practitioner identified in Section 3 will be rendering services on a regular basis. If more than four locations need to be provided, attach and submit this form as needed.

A. 1st Practice Location Information ☐ Add ☐ Delete Effective Date: _____

1. Practice Location Name Firstchoice Healthcare PC Date practitioner began/will start rendering services at this location (MM/DD/YYYY) _____

2. Practice Location Street Address Line 1
2013 Second Loop Rd Unit F

Practice Location Street Address Line 2

City Florence County/Parish Florence State S.C ZIP Code + 4 29501

Telephone Number (Ext.) (843) 678-9777 Fax Number (if applicable) (843) 665-2814 E-mail Address (if applicable) _____

B. 2nd Practice Location Information ☐ Add ☐ Delete Effective Date: _____

1. Practice Location Name Firstchoice Healthcare Date practitioner began/will start rendering services at this location (MM/DD/YYYY) _____

2. Practice Location Street Address Line 1
754 W. Carolina Ave

Practice Location Street Address Line 2

City Hartsville County/Parish Darlington State S.C ZIP Code + 4 29550

Telephone Number (Ext.) (843) 857-0202 Fax Number (if applicable) (843) 857-0208 E-mail Address (if applicable) _____

C. 3rd Practice Location Information ☐ Add ☐ Delete Effective Date: _____

1. Practice Location Name _____ Date practitioner began/will start rendering services at this location (MM/DD/YYYY) _____

2. Practice Location Street Address Line 1

Practice Location Street Address Line 2

City _____ County/Parish _____ State _____ ZIP Code + 4 _____

Telephone Number (Ext.) _____ Fax Number (if applicable) _____ E-mail Address (if applicable) _____

D. 4th Practice Location Information ☐ Add ☐ Delete Effective Date: _____

1. Practice Location Name _____ Date practitioner began/will start rendering services at this location (MM/DD/YYYY) _____

2. Practice Location Street Address Line 1

Practice Location Street Address Line 2

City _____ County/Parish _____ State _____ ZIP Code + 4 _____

Telephone Number (Ext.) _____ Fax Number (if applicable) _____ E-mail Address (if applicable) _____

SECTION 5: STATEMENT OF TERMINATION

This section is to be completed only if you are terminating your reassignment of benefits to the provider/supplier.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Complete, sign, and date the "Statement of Termination."

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

By his or her signature, the individual practitioner terminates the authority of the provider/supplier to claim or receive any fees or charges for the practitioner's services, and attests to the accuracy of the information provided on this form.

SECTION 6: REASSIGNMENT OF BENEFITS STATEMENT

The individual practitioner who will be reassigning benefits to the eligible provider/supplier must complete, sign, and date this Reassignment of Benefits Statement. Failure to do so will delay the processing of this application, thus hindering CMS's ability to make payments.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Type or print the individual practitioner's full name.
- The individual practitioner must sign and date this section.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

SECTION 7: ATTESTATION STATEMENT

Either the authorized official or a designated official who has been identified on the provider/supplier's CMS 855B application must sign and date this Attestation Statement. By his or her signature, the authorized or designated official attests to the accuracy of the information provided and certifies that the provider/supplier applying to receive payments is in fact eligible to receive reassigned benefits.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

For further information on the requirements regarding the reassignment of benefits, contact the Medicare carrier.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

This section is to be completed by the individual practitioner when terminating a previously authorized reassignment of benefits.			
By my signature, I hereby terminate the authority of _____ to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)			
I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.			
Individual Practitioner Name Print	First	Middle	Last Jr., Sr., etc.
Individual Practitioner Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

This section MUST be signed and dated by the individual practitioner shown in Section 3 to authorize the reassignment of his or her benefits to the provider/supplier shown in Section 2.			
Medicare law prohibits payment for services provided by an individual practitioner to be paid to another individual or provider/supplier unless the individual practitioner who provided the services specifically authorizes another individual or provider/supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 CFR 434.73 and 42 CFR 434.88. By signing this Reassignment of Benefits Statement, you are authorizing the individual or provider/supplier identified in Section 2 to receive Medicare payments on your behalf.			
Your employment or contract with this individual or provider/supplier must be in compliance with CMS regulations. All individual practitioners who allow another individual or provider/supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.			
I acknowledge that, under the terms of my employment or contract, _____ is entitled to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)			
Individual Practitioner Name Print	First	Middle	Last Jr., Sr., etc.
Individual Practitioner Signature	First, Middle, Last Jr., Sr., M.D., D.O., etc.)		Date (MM/DD/YYYY) Signed

This section requires the signature of an authorized or delegated official of the provider/supplier shown in Section 2. The authorized or delegated official must currently be on file with Medicare for this application to be processed.			
I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. I certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.			
Authorized/Delegated Official Name Print	First	Middle	Last Jr., Sr., etc.
Authorized/Delegated Official Signature	(First, Middle, Last Jr., Sr., M.D., D.O., etc.)		Date (MM/DD/YYYY) Signed

SECTION 2: PRACTITIONER IDENTIFICATION

A. **Personal Information** - The information furnished in this section will allow us to uniquely identify you in the Medicare program. Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Provide your full name.
2. If you previously used another name(s), including a maiden name, supply that under "Other Name."
3. Provide your date, State, and country of birth.
4. Indicate your gender.
5. Furnish your year of graduation and the school you attended for your Physician or Non-Physician Medical Specialty.

B. **Correspondence Address** - This section will assist us in contacting you with any questions we have concerning your business relationship with the Medicare program.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- You must provide an address and telephone number where we can contact you directly to receive any notices that may arise as a result of your enrollment in the Medicare program. It also may be necessary to send you important changes/information concerning the Medicare program that directly impacts you and/or your Medicare payments. Therefore, this address cannot be that of your billing agency, management service organization, or staffing company. You may furnish your home address and telephone number if you choose.

C. **Residency Status** - Your responses to the questions in this section will assist us in determining your eligibility to bill Medicare for the services you render to Medicare patients.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Check to identify if you are currently a resident, intern, or fellow at a health care facility.
- If "Yes," provide the name of the facility where you serve as a resident/intern/fellow.
- If "No," skip to Section 2D (Business Information).
2. State whether the services you render in the facility above in (Question 1) are part of your requirements for graduation from a formal residency program.
3. Indicate if you also render services at other facilities or practice locations.
If "Yes," you must report these other practice locations in Section 4 (Practice Locations).
4. Indicate if any services that you render, at any practice location you report in Section 4, are required for graduation from a formal residency program.
- If "Yes," indicate if the teaching hospital has agreed to incur all or substantially all costs of the training in the other facility or practice location.

D. **Business Information (if applicable)** - Complete this section if you operate your practice as a business under a name different from your individual name. This information is needed to correctly report to the Internal Revenue Service (IRS) all Medicare payments you receive and the tax identification number under which these payments are made.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. If this section does not apply to you, check the box provided and skip to Section 2B (Medical Specialty(s)).
2. Provide the legal business name you use when reporting tax information to the IRS. Supply your tax identification number as issued by the IRS.
3. Indicate whether your business is incorporated.

NOTE: If you answer "Yes" to number 3 above, you will need to complete two applications. One application will be to establish you with the Medicare program and the other application will be required to enroll your business. Once you complete the application identifying yourself, you must also enroll the business by completing the application for supplier billing Medicare carriers (CMS 855B). You must also complete a CMS 855R to reassign benefits payable to you as an individual practitioner to your business, which will be submitting claims for the services you have rendered. In addition, any other practitioners who render services for your business, who will be reassigning their benefits to the business, must also complete a CMS 855R.

This section is to be completed with information about yourself; where Medicare can contact you directly; whether you are rendering services in a health care facility as a resident or an intern; and whether you have established your practice as a separate business entity. You must also designate your medical specialty.					
A. Personal Information			☐ Change	Effective Date: <u>6/24/2007</u>	
1. Name	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
<u>Hugh</u>		<u>S</u>	<u>Thompson</u>		<u>MD</u>
2. Other Name (including Maiden)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
3. Date of Birth (MM/DD/YYYY)	State of Birth		Country of Birth		
<u>2/10/1940</u>	<u>Georgia</u>		<u>USA</u>		
4. Gender	☒ Male ☐ Female				
5. Year of Graduation (YYYY)	Medical School				
<u>1973</u>	<u>Medical University of South Carolina</u>				
B. Correspondence Address			☐ Change	Effective Date: <u>6/24/2007</u>	
You must furnish an address and telephone number where Medicare can contact you directly.					
Mailing Address Line 1					
<u>2013 Second Loop Rd Unit-F</u>					
Mailing Address Line 2					
City		State	ZIP Code + 4		
<u>Florence</u>		<u>S.C.</u>	<u>29501</u>		
Telephone Number	(Ext.)	Fax Number (if applicable)	E-mail Address (if applicable)		
<u>(843) 678-9777</u>		<u>(843) 665-2814</u>	<u>6224257@Tuna.Com</u>		
C. Residency Status			☐ Change	Effective Date: _____	
1. Are you currently:					☐ YES ☒ NO ☐ YES ☒ NO ☐ YES ☒ NO
a resident?					
an intern?					
in a fellowship program?					
IF YES to any of the above questions, provide the name of the facility where you are a resident, intern, or fellow on the line below:					

IF NO, skip to Section 2D (Business Information) below.					
2. Are the services that you render at the facility shown in Question 1 part of your requirements for graduation from a formal residency program?					☐ YES ☒ NO
3. Do you also render services at other facilities or practice locations?					☐ YES ☒ NO
IF YES, you <u>must</u> report these practice locations in Section 4 (Practice Location).					
4. Are the services that you render in any of the practice locations you will be reporting in Section 4 (Practice Location) part of your requirements for graduation from a formal residency program?					☐ YES ☒ NO
IF YES, has the teaching hospital reported in Question 1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility or location?					☐ YES ☒ NO
D. Business Information (if applicable)			☐ Change	Effective Date: _____	
1. Check here ☒ if this section does not apply to you and skip to Section 2E. Otherwise, furnish the following information if you operate your practice as a business under a name other than your own name.					
2. Legal Business Name as Reported to the IRS			Tax Identification Number		
3. Is your business incorporated?					☐ YES ☒ NO
IF YES, see specific instructions on how to enroll your health care business in the Medicare program.					

E. Medical Specialty

1. **Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

If you are a physician, please enter the appropriate letter (P - primary, S - secondary) to indicate your specialty(s). If you do not see your specialty listed, check "Undefined physician type" and report your specialty in the space provided. You must also submit copies of your State physician license, medical school degree, and your Federal controlled substance registration certificate from the Drug Enforcement Agency.

****NOTE: Diagnostic Radiology** - If you checked diagnostic radiology as your specialty, and you will bill for the technical component (tc) of the diagnostic test, you must contact the Medicare carrier prior to your enrollment to determine if you will also need to complete a CMS 855B to enroll in Medicare as an Independent Diagnostic Testing Facility (IDTF).

NOTE: Physicians who Bill for Diagnostic Tests (other than clinical laboratory or pathology tests) - As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who are not your patients. Patients are considered your own patients if:

- They have a prior relationship with you and are receiving medical treatment from you for a specific medical condition, or
- You are also billing for patient evaluation and management codes (E & M).

A separate (additional) enrollment as an IDTF may be required if, as stated above, substantial portions of your diagnostic tests (other than clinical laboratory or pathology) are provided to patients who are not your patients. Enrollment as an IDTF will not affect your enrollment as a physician. If you only furnish diagnostic tests, claims must be submitted as an IDTF. To enroll as an IDTF, you must complete and submit a CMS 855B.

2. **Non-Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

If you are a non-physician practitioner, enter the appropriate letter (P - primary, S - secondary) to indicate your specialty(s). If you do not see your specialty listed, check "Undefined non-physician type" and report your specialty in the space provided. All non-physician practitioners must meet specific licensing, educational (including any degrees), and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare carrier. Be sure to include copies of all necessary documentation to prove your eligibility to enroll in Medicare.

- F. **Supervising and/or Collaborating Physician(s)** - Indicate if you are adding or deleting a supervising and/or collaborating physician. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

- Furnish the name, social security number, and Medicare identification number of all applicable physicians who supervise or collaborate with you.

NOTE: All non-physician practitioners (including Physician Assistants who must complete Section 2f) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges (as required by Federal law) must complete this section. In addition, all supervising and/or collaborating physicians reported in this section must be currently enrolled in the Medicare program.

E. Medical Specialty(s)

Designate your specialty(ies) below using:

☒ Primary☒ Secondary (if applicable)**1. Physician Specialty**☐ Change

Effective Date: _____

Submit a copy of your State Physician License and Medical School Degree.

☐ Addiction medicine	☐ Hematology/Oncology	☐ Pathology
☐ Allergy/Immunology	☐ Infectious disease	☐ Pediatric medicine
☒ Anesthesiology	☐ Internal medicine	☐ Peripheral vascular disease
☐ Cardiac surgery	☐ Interventional radiology	☐ Physical medicine and rehabilitation
☐ Cardiovascular disease (Cardiology)	☐ Maxillofacial surgery	☐ Plastic and reconstructive surgery
☐ Chiropractic	☐ Medical oncology	☐ Podiatry
☐ Colorectal surgery (Proctology)	☐ Nephrology	☐ Preventive medicine
☐ Critical care (Intensivists)	☐ Neurology	☐ Psychiatry
☐ Dermatology	☐ Neuropsychiatry	☐ Pulmonary disease
☐ Diagnostic radiology** (see note)	☐ Neurosurgery	☐ Radiation oncology
☐ Emergency medicine	☐ Nuclear medicine	☐ Rheumatology
☐ Endocrinology	☐ Obstetrics/Gynecology	☐ Surgical oncology
☐ Family practice	☐ Ophthalmology	☐ Thoracic surgery
☐ Gastroenterology	☐ Optometry	☐ Urology
☐ General practice	☐ Oral surgery (Dentist only)	☐ Vascular surgery
☐ General surgery	☐ Orthopedic surgery	
☐ Geriatric medicine	☐ Osteopathic	
☐ Gynecological/Oncology	☐ manipulative treatment	
☐ Hand surgery	☐ Otolaryngology	
☐ Hematology	☒ Pain Management	
		Undefined physician type (Specify): _____

2. Non-Physician Specialty☐ Change

Effective Date: _____

See instructions for specific non-physician requirements that must be met to enroll in the Medicare program. You must submit documentation (e.g., copies of licenses, degrees) that confirms you have met the requirements for your specialty.

☐ Audiologist	☐ Registered Dietitian or Nutrition Professional
☐ Certified clinical nurse specialist	☐ Physical therapist in private practice (see Sec. I)
☐ Certified nurse midwife	☐ Physician assistant (see Section J)
☐ Certified registered nurse anesthetist	☐ Psychologist, Clinical (see Section G)
☐ Licensed clinical social worker	☐ Psychologist billing independently (see Section H)
☐ Mass immunization roster biller	☐ Undefined non-physician type (Specify): _____
☐ Nurse practitioner	
☐ Occupational therapist in private practice (see Sec. I)	

F. Supervising and/or Collaborating Physician(s)☐ Add☐ Delete

Effective Date: _____

This section must be completed by all non-physicians (excluding physician assistants) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges. The supervising and/or collaborating physician must be currently enrolled with Medicare.

Physician Name	Social Security Number	Medicare Identification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

G. Clinical Psychologists - Questionnaire

Questions 1-4: All clinical psychologists must respond to these questions by checking "Yes" or "No" to determine your eligibility to bill Medicare.

H. Psychologists Billing Independently - Questionnaire

A psychologist billing independently is defined as:

- One who renders services free of the administrative and professional control of an employer such as a physician, institution, or agency, and
- Who maintains office space at his/her own expense and furnishes services only in that space or the patient's home, and
- Has the right to collect fees for the services rendered, and
- The patients treated are the psychologist's own patients.

Questions 1-4: All psychologists must respond to these questions by checking "Yes" or "No" to determine if you are eligible to bill Medicare as a psychologist who is independently billing.

I. Occupational/Physical Therapist in Private Practice (OT/PT) Only - Questionnaire

An occupational therapist/physical therapist in private practice is defined as one who maintains a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space must be owned, leased, or rented by the OT/PT and used for the exclusive purpose of operating the OT's/PT's practice.

Questions 1-5: All OTs/PTs must respond to these questions by checking "Yes" or "No." This information will determine your eligibility to bill Medicare.

J. Physician Assistants (PA) Only - Indicate if you are adding or deleting an employer. Provide the new information and the effective date of the addition or deletion. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Furnish the name, social security number and date of birth of the name and Medicare identification number of the physician listed on your degree or license. For States that do not require the Supervising Physician to be identified on the PA license, provide the information required in this section about the physician who qualified you for your license.
2. In order to determine who will be billing for your services, report all employers' Medicare billing numbers. This information will allow Medicare to appropriately associate you with each of your employers.

NOTE: Physician Assistants - When completing this application, PAs should only complete Sections 1, 2, 3, 10, 13, 15 and 17. Also, PAs should not use or submit the CMS 855R form to report employers. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to the practitioner.

G. Clinical Psychologists - Questionnaire

This section must be completed by all clinical psychologists in order to determine if you are eligible to bill Medicare. Please answer all questions in this section.

1. Do you hold a doctoral degree in psychology?
If YES, furnish the field of your psychology degree. ☐ YES ☐ NO
2. Do you inform each Medicare patient of the desirability of consulting with the patient's attending or primary care physician to consider potential medical conditions contributing to the patient's condition? ☐ YES ☐ NO
3. Contingent upon the patient's consent, do you consult with the patient's designated attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality? ☐ YES ☐ NO
4. If the patient assents to the consultation, do you attempt to consult with the patient's physician within a reasonable time after receiving consent? ☐ YES ☐ NO

H. Psychologists Billing Independently - Questionnaire

This section must be completed by all psychologists billing independently in order to determine if you are eligible to bill Medicare as a psychologist billing independently. Please answer all questions in this section.

1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is your private practice located in an institution?
If YES to question 4 above, please answer questions "a" and "b" below. ☐ YES ☐ NO
- a) If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO
- b) If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

I. Occupational/Physical Therapist in Private Practice (OT/PT) - Questionnaire

This section must be completed by all occupational and physical therapists in order to determine if you are eligible to bill Medicare for services rendered in your private practice. Please answer all questions in this section.

1. Are all of your PT/OT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide PT/OT services outside of your office and/or patients' homes?
If YES, provide a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services. ☐ YES ☐ NO

J. Physician Assistants Only

☐ Add

☐ Delete

Effective Date: _____

This section must be completed by all physician assistants to ensure correct claims coding when billing for your services.

1. Provide the name, social security number and date of birth, or the name and Medicare Identification Number of the physician shown on your PA degree or license in the space below. See instructions if no physician is shown.

Name First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
------------	--------	------	----------------	------------------

Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number (if applicable)
------------------------	----------------------------	--

2. Since physician assistants cannot bill the Medicare program directly, they must report the Medicare billing number for all employers that bill Medicare for their services.

SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against you. See Table A on the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change." provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. You must state whether, under any current or former name or business identity, you have EVER had any of the adverse legal actions listed in Table A of the application form imposed against you.
2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action, criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notice, etc.).

If you are uncertain as to whether you fall within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, you should query the Medicare Integrity and Protection Data Bank. If you need information on how to access the data bank, call 1-800-767-6732 or visit www.medicare.gov. There is a charge for using this service.

Table A - This is the list of adverse legal actions that must be reported.

B. Overpayment Information - Current law's fixed in the Federal Statutory Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identities. Failure to furnish information about overpayments will put you in violation of these Acts and subject it to possible denial of its Medicare enrollment.

If reporting a change to existing information, check "Change." provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. You must report all outstanding Medicare overpayments that you are liable for, including those paid to you, or on your behalf under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets all of the conditions listed below:
 - a) The overpayment arose out of your current or previous enrollment in Medicare. This includes any overpayment incurred by you under a different name or business identity, or in another Medicare contractor jurisdiction.
 - b) CMS (or its contractor) has determined that you are liable for the overpayment, and
 - c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractor), nor is the overpayment amount being repaid through the withholding of Medicare payments to you.
- Any overpayment not meeting all of these conditions should not be reported.
2. Furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after your enrollment has been approved do not need to be reported unless you are enrolling with a different Medicare contractor.

INTERACTIVE CORRESPONDENCE ONLINE REPORTING
ICOR CASE HEADER

INQ VMSICB3
7RK 08/19/02

DCN: 02024900202 DOR 01/22/02 TQE 11:54:01 LTR 04 / 000
FROM 468882706 BPO 0 NAME EVANGELISTA, P.A. NICK R
NAME2 LOW COUNTRY ORTHOPEDICS TEAM
ADDR1 717 SOUTH STATE ST ADDR2 STE 900
C/S/Z FAIRMONT MN 56031 - 4469 ADDR3
FOR HICN CCN A RD IST
PROV F/T DTES / / / / / CALLER
ASGN 7RH DATE 04/02/02 OFID 7RH PHONE# EXT
ORIG 001 MAIL TYPE 85I 855I INDIVIDUAL ENROLLMENT
DEPT 009 PROVIDER CERTIFICATION STAT 90 COMPLETED WITH LETTERS
LOCN 061 PROVIDER CERTIFICATION WRIT DOD 04/02/02 DRN
RK NEW UPIN #S72808 JOINED TO NEW GROUP #7250. <----->
1ST. NOTE: RET 85-I FOR SECTIONS 4A, 85-R FOR SECTIONS 4A, 7-COPY OF 02

CLAIMS / / / MDD - AD 0000 AB 0000 ABP 0000
DRD / / / DOE / / / N-REWARDS
AD 0000 DD 0000 RD 0000 CTRSY S
UPU 0000 UPW 0000 REWARD S
NEXT DCN PF9/21-PROCESS PF11/23-NOTEPAD

C142-HISTORY RECORD - STATIC

02024900202 60880

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against you (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History

☐ Change

Effective Date: _____

1. Have you, under any current or former name or business identity, ~~still~~ had any of the adverse legal actions listed in Table A below imposed against you? ☒ YES ☐ NO
2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:

Date:

Law Enforcement Authority:

Resolution:

Exclusion6/30/94DHHS - OIGReinstatementLIC Suspension5/31/94SC. Med Board4/14/94

Table A

- 1) Any felony or misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- 2) Any felony or misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- 3) Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- 4) Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- 5) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
- 6) Any revocation or suspension of accreditation.
- 7) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
- 8) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

☐ Change

Effective Date: _____

1. Do you, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☒ NO
2. IF YES, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:

Account number under which the overpayment exists:

This section is to be completed with information about where you currently render medical services to Medicare patients. You must complete this entire section beginning with Section 4A1 and carefully follow all instructions in each part. If you need additional space to report additional groups/organizations or if you have more than one private practice location, copy and complete this section as needed for each.

A. Group Practice Information

Beginning with Section 4A1, answer "Yes" or "No" to each question. When applicable, furnish the group/organization name and Medicare number for each group/organization to which you will reassign your benefits. In addition to identifying the group/organization to which you will reassign your benefits in this section, either you or each group/organization reported in this section must also complete and submit a CMS-858R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill Medicare for the services you have rendered in the group/organization practice location.

1. Will all of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☒ YES ☐ NO
 IF YES, furnish the name and Medicare identification number of each group or organization below and skip to Section 14 (Penalties for Falsifying Information on this Enrollment Application).
 IF NO, proceed to Question 2 below.

a) Name of Group/Organization <i>Firstchoice Healthcare PC</i>	Group/Organization Medicare Number <i>14672</i>
b) Name of Group/Organization <i>Firstchoice Healthcare PC</i>	Group/Organization Medicare Number <i>6873</i>
c) Name of Group/Organization	Group/Organization Medicare Number

2. Will any of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☒ NO
 IF YES, furnish the name and Medicare identification number of each group or organization below and continue completing the rest of this application at Section 4B.
 IF NO, continue with Section 4B below with information about your private practice.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

B. Practice Location Information ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Practice Location Name Date you started practicing at this location (MM/YYYY)

2. Practice Location Street Address Line 1

Practice Location Street Address Line 2

City	County/Parish	State	ZIP Code + 4
Telephone Number () () ()	(Ext.) ()	Fax Number (if applicable) () () ()	E-mail Address (if applicable)

3. Do you own/lease this practice location? ☐ YES ☐ NO

4. Is this practice location a: ☐ YES ☐ NO
 private practice office setting?
 hospital? ☐ YES ☐ NO
 retirement/assisted living community? ☐ YES ☐ NO
 other health care facility? (Specify): _____ ☐ YES ☐ NO

5. CLIA Number for this location (if applicable) FDA/Radiology (Mammography) Certification Number for this location (if applicable)

- C. Medicare Payment "Pay To" Address Information** - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, furnish the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

If you are enrolling for the first time, state where you want your Medicare payments to be sent. The ability to establish more than one "Pay-To"-address will be addressed by the local Medicare carrier. Therefore, if you want to establish multiple "Pay-To"-addresses you need to contact the carrier. Some Medicare carriers do not allow multiple payment addresses.

- Provide the P.O. Box or street address, city, State and ZIP Code for your payment address.

If you would like your payments to be deposited to your bank account electronically, place a check in the box given and complete the "Medicare Authorization Agreement for Electronic Funds Transfer" (Form HCFA-588). Payment will be made in your name as shown in Section 2A1 or your legal business name as shown in Section 2D2.

- If payment is being paid by electronic funds transfer (EFT), the "Pay To" address should indicate where you want all other payment information, (e.g., remittance notices, special payments, etc.) sent.

- D. Location of Patients' Medical Records** - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. If all of your patients' medical records are located at the practice location in Section 4B, check the box provided and skip this section.
2. If any of your patients' medical records are stored in a location other than the practice location in Section 4B, complete this section with the complete address of all storage locations.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained.

- E. Comments** - This section is to be used as an opportunity to explain any unusual circumstances concerning your practice location, "Pay To" address, the location of your patients' medical records, or how they are maintained and/or stored.

G. Medicare Payment "Pay To" Address Information ☐ Change ☐ Effective Date: _____		
Furnish the address where payments should be sent for services rendered at the practice location in Section 4B.		
"Pay To" Address Line 1		
"Pay To" Address Line 2		
City	State	ZIP Code + 4
Check here ☐ and submit a completed Form HCFA-554 with this application if you would like to have your payments electronically transferred to your bank account.		
D. Location of Patients' Medical Records ☐ Add ☐ Delete ☐ Change ☐ Effective Date: _____		
1. Check here ☐ if <u>all</u> of your patients' medical records are stored in the practice location(s) shown in Section 4B, and skip this section.		
2. If <u>any</u> of your patients' medical records are stored in a location other than the practice location(s) shown in Section 4B, complete this section for each additional storage location.		
Name of Storage Facility/Location		
Street Address Line 1		
Street Address Line 2		
City	State	ZIP Code + 4
E. Comments		
Explain any unique or unusual circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes (house calls only)).		

SECTION 5: MANAGING CONTROL INFORMATION (ORGANIZATIONS)

OAG Approval No. 033-0003

This section is to be completed with information about any organization that manages your practice. See explanation below of organizations that should be reported in this section. If individually, and not organization, manage your practice, do not complete this section. These individuals must be reported in Section 6. If there are more than three organizations, copy and complete this section as needed.

A managing organization is defined as any organization that exercises operational or managerial control over the practitioner's practice/business, or conducts the day-to-day operations of the practitioner's practice/business. This could be a management services organization, either under contract or through some other arrangement with the practitioner to furnish management services for any of his/her practice/business location(s).

In most situations when you use a management services organization, the organization would be reported in this section and the individual person from the organization who works in your office, or handles the management or administrative duties from outside your office, would be reported in Section 6.

A. Check Box - Check the box if there are no organizations to be reported in this section. If this box is checked, proceed to Section 6.

B. 1st Organization with Managing Control - Identification Information - Indicate if you are selling or donating a managing organization, or changing information about an existing managing organization. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the legal business name and effective date of managing control.
2. Provide the managing organization's "doing business as" name (if applicable) and its tax identification number.
3. Provide the managing organization's business street address and its Medicare identification number (if applicable).

IMPORTANT - Only organizations should be reported in Section 5. Individuals must be reported in Section 6.

C.D. 1st and 3rd Organization with Managing Control - Identification Information - Sections 3C and 3D may be used to provide information about additional managing organizations. Follow the instructions in Section 5B.

This section is to be completed with information about all organizations that manage the day-to-day operations of the enrolling practitioner's practice. See instructions for an explanation of organizations that should be reported here. If there are more than three management organizations, copy and complete this section as needed.		
A. Check here ☐ if this section does not apply and skip to Section 6.		
B. 1st Organization with Managing Control—Identification Information ☐ Add ☐ Delete ☐ Change Effective Date: _____		
1. Legal Business Name as Reported to the IRS	Effective Date of Managing Control (MM/DD/YYYY)	
2. "Doing Business As" Name (if applicable)	Tax Identification Number	
3. Business Address Line 1	Medicare Identification Number(s) (if applicable)	
Business Address Line 2		
City	State	ZIP Code + 4
C. 2nd Organization with Managing Control—Identification Information ☐ Add ☐ Delete ☐ Change Effective Date: _____		
1. Legal Business Name as Reported to the IRS	Effective Date of Managing Control (MM/DD/YYYY)	
2. "Doing Business As" Name (if applicable)	Tax Identification Number	
3. Business Address Line 1	Medicare Identification Number(s) (if applicable)	
Business Address Line 2		
City	State	ZIP Code + 4
D. 3rd Organization with Managing Control—Identification Information ☐ Add ☐ Delete ☐ Change Effective Date: _____		
1. Legal Business Name as Reported to the IRS	Effective Date of Managing Control (MM/DD/YYYY)	
2. "Doing Business As" Name (if applicable)	Tax Identification Number	
3. Business Address Line 1	Medicare Identification Number(s) (if applicable)	
Business Address Line 2		
City	State	ZIP Code + 4

SECTION 6: MANAGING EMPLOYEE INFORMATION

This information is necessary to ensure that any managing employees you have hired, or managing individuals working at any of your practice locations, meet all the conditions of participation in the Medicare program.

A managing employee is defined as any individual (other than yourself), including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over your practice/location, or who conducts the day-to-day operations of your practice/business. For Medicare enrollment purposes, a managing employee also includes any individual that manages your day-to-day operations, either under contract or through some other arrangement, but who is not your actual employee.

All managing employees at any of your practice locations shown in Section 4B must be reported in this section. Do not report individuals employed by hospitals, health care facilities or other organizations shown in Section 4B, or managing employees of any group or organization to which you assign your benefits. For instance, the CEO of a hospital where one of your practice locations is situated should not be reported.

If you have more than two managing employees, copy and complete this section as needed.

A. Check Box - If you do not have a managing employee who meets the above definition, check the box provided and skip this section. Otherwise, provide information about all managing employees.

B. Identifying Information - Indicate whether you are adding or deleting a managing employee, or changing information about an existing managing employee. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the full name of the managing employee.
2. Provide the managing employee's social security number as required by Sections 1124 and 1124A of the Social Security Act, and furnish his/her date of birth and Medicare identification number (if applicable).
3. Indicate if this managing employee is actually employed by you (on your payroll as a W-2 employee).

C. Adverse Legal History

This section must be completed for all managing employees who are actually employed by you.

1. You must state whether the managing employees reported above, under any current or former name, or business identity, has ever had any of the adverse legal actions listed in Section 3A (Table A) of this form imposed against him or her.
2. If the answer to this question is "Yes," supply all requested information. Attach a copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If you are uncertain as to whether the managing employee falls within one of the adverse legal action categories, you should review the Healthcare Integrity and Protection Data Bank. If you need information on how to access the data bank, call 1-800-767-6732 or visit www.hipdb.com.

D-E. Identifying Information/Adverse Legal History - Section 6D and 6E are additional sections to provide information about a second managing employee. Follow the instructions in Sections 6B and 6C above.

SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been omitted.

This section is to be completed with personal identification information (including adverse legal history) about all managing employees. See instructions for the definition of managing employee(s) to determine who should be reported here. If there are more than two managing employees, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 5.

B. Identifying Information ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Name First Middle Last Jr., Sr., etc.

2. Social Security Number Date of Birth (MM/DD/YYYY) Medicare Identification Number (if applicable)

3. Is the above individual your own employee? ☐ YES ☐ NO

C. Adverse Legal History ☐ Change Effective Date: _____

Complete this section only if the above individual is your own employee.

1. Has the employee reported in Section 8B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

D. Identifying Information ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Name First Middle Last Jr., Sr., etc.

2. Social Security Number Date of Birth (MM/DD/YYYY) Medicare Identification Number (if applicable)

3. Is the above individual your own employee? ☐ YES ☐ NO

E. Adverse Legal History ☐ Change Effective Date: _____

Complete this section only if the above individual is your own employee.

1. Has the employee reported in Section 8D above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 8: BILLING AGENCY

The purpose of collecting this data is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program. A billing agency is a company or individual you hired or contracted with to furnish claims processing functions for your practice. Any entity that meets this description must be reported in this section. If you have an agreement with a billing agency and that company has a subcontract with a clearinghouse for electronic claims submission, you must report the clearinghouse in Section 9, with a copy of the electronic data interchange agreement submitted with this application.

- A. Check Box** - If you do not have a billing agency, check the box and skip to Section 9.
- B. Billing Agency Name and Address** - Indicate if you are adding or deleting a billing agent and/or making a change concerning your existing relationship with your billing agency. Provide the new information and the effective date of the change. Provided that this is the only change you are making, you will need to sign and date the certification statement. Otherwise, if you use a billing agency:
1. Provide the billing agency's legal business name and tax identification number.
 2. If the billing agency has a "doing business as" name, provide that information in this space.
 3. Provide the street address, telephone number, fax number and e-mail address of the billing agency.

C. Billing Agreement/Contract Information

You are responsible for answering the questions listed. These questions are designed to show that you fully understand and comprehend your billing agreement and that you intend to adhere to all Medicare laws, regulations, and program instructions. If you do not understand a question or you need help in interpreting your agreement, contact the Medicare carrier. At any time, the carrier may request copies of all agreements/contracts associated with this billing agency.

This section is to be completed if you use or contract with a billing agency to submit claims to Medicare on your behalf. If you use more than one billing agency, copy and complete this section for each. You may be required to submit a copy of your current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

A. Check here ☐ If this section does not apply and skip to Section 6.

B. Billing Agency Name and Address ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Legal Business Name as Reported to the IRS

Tax Identification Number

2. "Doing Business As" Name (if applicable)

3. Business Street Address Line 1

Business Street Address Line 2

City

State

ZIP Code + 4

Telephone Number

(Ext.)

Fax Number (optional)

E-mail Address (optional)

C. Billing Agreement/Contract Information

☐ Change

Effective Date: _____

Answer the following questions about your agreement/contract with the above billing agency.

1. Do you have unrestricted access to your Medicare reimbursement notices?

☐ YES ☐ NO

2. Does your Medicare payment go directly to you?

☐ YES ☐ NO

IF NO, proceed to Question 3.

IF YES, skip Questions 3, 4 and 5.

3. Does your Medicare payment go directly to a bank?

☐ YES ☐ NO

IF NO, proceed to Question 4.

IF YES, answer the following questions and skip Questions 4 and 5.

a) Is the bank account in your name only?

☐ YES ☐ NO

b) Do you have unrestricted access to the bank account and statements?

☐ YES ☐ NO

c) Does the bank only answer to you regarding what you want from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)?

☐ YES ☐ NO

4. Does your Medicare payment go directly to your billing agent?

☐ YES ☐ NO

IF NO, proceed to Question 5.

IF YES, answer the following question and skip Question 5.

a) Does the billing agent cash your check?

☐ YES ☐ NO

IF NO, proceed to Question b.

IF YES, are all of the following conditions included in the billing agreement?

1) The agent receives payment under an agency agreement with you.

2) The agent's compensation is not related in any way to the dollar amounts billed or collected.

3) The agent's compensation is not dependent upon the actual collection of payment.

4) The agent acts under payment disposition instructions that you may modify or revoke at any time.

5) In receiving payment, the agent acts only on your behalf (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services).

☐ YES ☐ NO

b) Does the billing agent either give the Medicare payment directly to you or deposit the payment into your bank account?

☐ YES ☐ NO

5. Who receives your Medicare payment? _____

SECTION 9: ELECTRONIC CLAIMS SUBMISSION INFORMATION

This section is to be completed with information about any clearinghouse(s) that you use for electronic claims submission services, or if your billing agency or management services organization has a subcontract with a clearinghouse to submit your claims electronically. A copy of all EDI agreements between the clearinghouse(s) and the carrier(s) must be submitted with this application.

If you would like to submit claims electronically once you are enrolled in the Medicare program, you will need to complete an Electronic Data Interchange (EDI) agreement with your local Medicare carrier. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number issued to you.

At the time of initial enrollment, if you know you will be submitting claims electronically through the use of a clearinghouse(s) and you know the clearinghouse(s) you will use, report the clearinghouse(s) in this section.

If you are already enrolled in Medicare and you are submitting this form to report that you (or your billing agency or management services organization) will begin submitting claims electronically through a clearinghouse, you must report the clearinghouse(s) in this section.

A. Check Box - Indicate if you or your billing agent does not use a clearinghouse. If checked, skip to Section 10.

B. Check Box - Indicate if you would like to submit claims electronically. Checking this box will alert the carrier to contact the claims processing department to process an EDI agreement once your enrollment has been completed and approved and a Medicare billing number issued.

C. Clearinghouse Name and Address - Indicate if you (or your billing agent) is adding or deleting a clearinghouse and/or making a change concerning your existing relationship with a clearinghouse. Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the clearinghouse.
2. If the clearinghouse uses a "doing business as" (DBA) name with you, furnish that information in this space. If the clearinghouse has more than one DBA name with you, report all that apply for Medicare claims.
3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the clearinghouse.

NOTE: If you use a clearinghouse and a copy of the EDI agreement has not been prepared and submitted, contact the carrier to start this process.

SECTION 10: STAFFING COMPANY

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If you have an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

A. Check Box - If you do not work for (or do not contract with) a staffing company, check this box and skip to Section 13.

B. Staffing Company Name and Address - Indicate if you are "adding," "deleting," or "making a change," concerning your relationship with an existing staffing company by checking the appropriate box. Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.
2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with you, report all that apply for Medicare claims.
3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. Staffing Company Contract/Agreement Information

Respond to the questions asked in this section to indicate that you fully understand and comprehend your contract with the staffing company and that you plan to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

This section is to be completed with information about any company (clearinghouse) you use or contract with for electronic claims submission services. See the instructions to determine when and how this section is to be completed. If you submit (or will be submitting) claims electronically without the use of a 3rd party company (clearinghouse), check the box in Section 9A and submit a copy of your electronic data interchange (EDI) agreement if one has been established or check the box in Section 9B to start the EDI agreement process. If you use more than one clearinghouse, copy and complete this section for each. A copy of all currently established EDI agreements **MUST** be submitted with this application.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Check here ☐ if enrolling in Medicare for the first time and would like to submit claims electronically.

C. Clearinghouse Name and Address ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Legal Business Name as Reported to the IRS

Tax Identification Number

2. "Doing Business As" Name (if applicable)

3. Business Street Address Line 1

Business Street Address Line 2

City

State

ZIP Code + 4

Telephone Number

(Ext.)

Fax Number (optional)

E-mail Address (optional)

This section is to be completed if you are employed by, or under contract to render medical services with, a company that staffs health care organizations (e.g., hospital emergency rooms) with medical professionals to treat patients. If you are employed by or under contract with more than one staffing company, copy and complete this section for each. You may be required to submit a copy of your current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 13.

B. Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date: _____

1. Legal Business Name as Reported to the IRS

Tax Identification Number

2. "Doing Business As" Name (if applicable)

3. Business Street Address Line 1

Business Street Address Line 2

City

State

ZIP Code + 4

Telephone Number

(Ext.)

Fax Number (optional)

E-mail Address (optional)

C. Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and your contract/agreement with it.

1. If you have a contract/agreement with both a billing agency and a staffing company, does the staffing company shown in Section 10B and the billing agency identified in Section 8B have a common owner(s)? ☐ Not applicable ☐ YES ☐ NO

2. If you have a contract/agreement with both a billing agency and a staffing company (even if the billing agency and staffing company are the same), are there any provisions in your staffing company contract/agreement that supersede or contradict your billing agreement? ☐ Not applicable ☐ YES ☐ NO

SECTION 11 SURETY BOND INFORMATION

This section has been omitted.

SECTION 12 CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been omitted.

SECTION 13: CONTACT PERSON(S) - OPTIONAL

To assist in the timely processing of your application, you may want to provide the full name and telephone number of one or two individuals who can be reached to answer questions regarding the information furnished in this application. You are not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to you.

- A. **Check Box** - If you do not have a contact person, check this box and skip to Section 14.
- B. **1st Contact Name and Telephone Number** - Indicate if you are completing this section to add or delete a contact person(s) currently on file. State the effective date for the change. If you are changing existing information, check the applicable box and provide the effective date of the change, and sign and date the certification statement. Otherwise:
 - Furnish the name, e-mail address, and telephone number of an individual who can answer questions about the information furnished in this application.
- C. **2nd Contact Name and Telephone Number** - Same as "B" above.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

This section explains the penalties for deliberately furnishing false information to acquire or maintain enrollment in the Medicare program. You should review this section to ensure that you understand those penalties that can be applied against you for deliberately furnishing false information in this Medicare enrollment application.

This section is to be completed with the name(s) and telephone number(s) of a person(s), other than yourself, who can answer questions about the information furnished in this application. You do not need to furnish any names if you want all questions directed to you.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. 1st Contact Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:

Name First	Last	E-mail Address (if applicable)	Telephone Number (Ext.)

C. 2nd Contact Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:

Name First	Last	E-mail Address (if applicable)	Telephone Number (Ext.)

This section explains the penalties for deliberately furnishing false information to gain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000 (18 U.S.C. § 3671). Section 3671(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1126B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

- knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
- conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1126A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency... a claim... that the Secretary determines is for a medical or other item or service that the person knows or should know:

- was not provided as claimed; and/or
- the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

As an individual practitioner, you are the only person who can sign this application. This applies not only to initial enrollment and revalidation, but also to any changes and/or updates (e.g., new practice location, change in specialty, address changes, etc.) to your status in the Medicare program. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met. Your signature must be an original. Faxed, photocopied, or stamped signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL

This section has been omitted.

SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses (business and professional) that are required by the State where your practice is located must be included with this application.

All enrolling practitioners are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations as required by the practitioner's State to operate as a health care supplier (e.g., CLIA and FDA mammography certification, hazardous waste disposal license, etc.). The Medicare contractor will supply specific licensing requirements for your supplier type upon request.

In lieu of copies of the above requested documents, you may submit a notarized Certificate of Good Standing from the State licensing/certification board or other medical association. This certification cannot be more than 30 days old.

If you have had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0045. The time required to complete this information collection is estimated as 3-5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, NT-14-26, Baltimore, Maryland 21244-1850.

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

- 1.) I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.
- 2.) I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner may require the submission of a new application.
- 3.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
- 4.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on my compliance with any applicable conditions of participation in Medicare.
- 5.) Neither I, nor any W-2 managing employee, is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
- 6.) I agree that any existing or future overpayment made to me by the Medicare program may be recouped by Medicare through the withholding of future payments.
- 7.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
- 8.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
- 9.) I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

Practitioner Name First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Hugh	S	Thompson		MD
Practitioner Signature			Date (MM/DD/YYYY) Signed 7/30/02	
First, Middle, Last, Jr., Sr., M.D., D.O., etc.)				

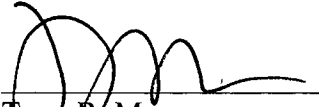
This section is a list of documents that, when applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) that you are including with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all professional school degrees or certificates or evidence of qualifying course work
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all controlled substance registration certificates from the Federal Drug Enforcement Agency
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Copy(s) of all current electronic data interchange (EDI) agreements
- ☐ Completed Form HCFA-480 - Medicare Participating Physician or Supplier Agreement
- ☐ Completed Form HCFA-688 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form CMS 855R - Individual Reassignment of Benefits
- ☐ IRS documentation confirming the Tax Identification Number with the Legal Business Name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed

CERTIFICATE OF COUNSEL -- RULE 210(g), SCACR

Counsel for Appellant certifies to the best of his knowledge, information, and belief, that the record contains all material proposed to be included by the parties and does not contain any material irrelevant to this appeal.



Tony R. Megna
Counsel for Appellant
3400 West Avenue
Columbia, SC 29203
803-799-1700

April 12, 2012.

**THE STATE OF SOUTH CAROLINA
In the Court of Appeals**

**APPEAL FROM DARLINGTON COUNTY
Court of Common Pleas
Honorable J. Michael Baxley
Circuit Court Judge**

**CIVIL ACTION NO: 2010-CP-16-0332
TRACKING NO: 2011203391**

Pee Dee Health Care, P.A.,

Appellant,

v.

**Hugh S. Thompson, III,
Louise T. Dailey as Personal
Representatives of the Estate
of Hugh S. Thompson,**

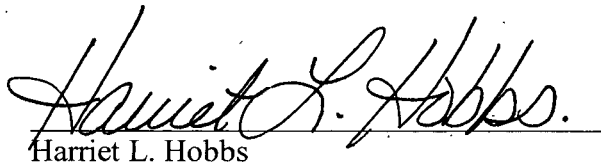
Respondent.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 13 day of April, 2012 a copy of the Record on Appeal in the above referenced matter has been served upon each of the following, by depositing a copy of same in the United States Mail, with sufficient postage annexed thereto, as follows:

Jay James, Esquire
PO Box 507
Darlington, SC 29540

Renee Josey, Esquire
931 S. Irby Street
Florence, SC 29501


Harriet L. Hobbs