Application Summary

 F-1585 App#24043 ETRO HTSD

Application Detail

License Type:	**Home Medical Equipment: Licensed**
Application:	**Home Medical Equipment: Initial Application**
Application Date:	**05/18/2026 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**Medical Services of America, Inc. DBA MedXpress**
Organization Type:	**Corporation**

Addresses

Main Address

Address:	**171B Monroe Lane** **LEXINGTON** **Lexington, SC** **29072** **US**
Phone Number:	**803-358-6760**
Extension:	
E-mail Address:	**licensing@msahealthcare.com**

Administrative

Name:	**Medical Services of America, Inc.** DBA MedXpress
Address:	**171B Monroe Lane** **LEXINGTON** **Lexington, SC** **29072** **US**
Phone Number:	**803-358-6760**
Extension:	

Verified 7/27/26 CNS

E-mail Address: **licensing@msahealthcare.com**

Emergency Contact

Name: **Medical Services of America, Inc.** dba MedXpress

Address: **171B Monroe Lane**

LEXINGTON

Lexington, SC

29072

US

Verified 7/27/26 (NS)

Phone Number: **803-358-6760**

Extension:

E-mail Address: **licensing@msahealthcare.com**

Ownership of Building

Name: **Medical Services of America, Inc.**

Address: **171B Monroe Lane**

LEXINGTON

Lexington, SC

29072

US

Phone Number: **803-358-6760**

Extension:

E-mail Address: **licensing@msahealthcare.com**

Legal Entity

Name: **Medical Services of America, Inc.**

Address: **171 Monroe Lane**

LEXINGTON

Lexington, SC

29072

US

Phone Number:	**803-358-6760**
Extension:	
E-mail Address:	**licensing@msahealthcare.com**

License Attributes Selected

Qualification/Certification	**All Counties**
Additional License Information	**For Profit** out of State South Carolina

Basic License Data

If your facility has branch offices provide the number. If none, enter 00	**00**
Provide Administrator's Name:	**Christopher Turner**
Provide the Ownership's Name:	~~Medical~~ Services of America, Inc
Is your facility accredited by a federally approved accrediting body?	**Yes** (Verified NS 7/27/2026)
If answered yes accredited, must provide expiration date of accreditation.	09/28/26 (NS 7/27/2026 Verified) **(mm/dd/yyyy)**
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	**Free Standing**
Provide a Yes or No, if your facility is Chain Affiliated:	**No**
Provide a Yes or No, if your facility has a Holding Company:	**No**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**Yes**
Provide a Yes or No, if your facility has a parent company:	**No**
Do you have a contract with a management firm to operate this facility?	**No**
Have any owners ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state?	**No**
Does your facility have a physical location in	**No**

Tennessee?:

Administrator Conviction Information

Administrator convicted of crime?:	**No**

Individual Owners, Partners, Director or Head of Government Entity

The name of the individual owner, partner, director of the corporation or head of the government:	**Christina M. Jeffcoat (COO/ Executive VP/ Secretary)**
Street:	**171 Monroe Lane**
City:	**Lexington**
State:	**South Carolina**
Zip:	**29072**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?:	**No**
Have any of owners of the disclosing entity had a suspension of admissions?:	**No**
Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?:	**No**

File Attachments

1102 COI Exp 10.01.2026.pdf

Fees

Initial License Fee	**$1404.00**
Total Amount Due:	**$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Medical Equipment facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Medical Equipment facility.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

July 27, 2026 Sent Via Email

Christopher Turner
Medical Services of America, Inc. dba MedXpress
171B Monroe Lane
Lexington, South Carolina 29072

Facility Type: Home Medical Equipment

Dear Christopher Turner:

It is my pleasure to inform you that your application for licensure of Medical Services of America, Inc. DBA MedXpress located at 171B Monroe Lane, Lexington, South Carolina 29072 has been initially approved for providing DME/HME services in all counties in Tennessee effective July 27, 2026 . The license number shall be 1585. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for August 26, 2026 . **You are hereby authorized to commence operation pending the final decision of the Commission**.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Tennessee Regional Office phone number is 865-594-9396 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone : (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1585 County: Lexington

Initial X Renovation _____ Satellite/Off Campus Location _____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: Medical Services of America DBA MedXpress 171 B Monroe Lane Lexington S.C. 29072

Application and fee on file in Central Office (CO)? Yes X No __ CON #: ___ Project #: __ Phase: _____ of __

Facility approved for Home Medical Equipment (HME): Providing DME/HME services in all counties in Tennessee.

Sprinklered: _____(Full 100%) Partial: _____(%)

Licensed bed count from: 0 to 0 Number of beds increased/decreased: 0

If secured unit, number of beds in unit: N/A If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: Nancy Mullins RN Date: 07/17/26

Fire Safety: See attached application Date: _____

CD Approved: Yes ___ No___ N/A x Health Survey Required: Yes X No ____; if Yes, please indicate which region: EAST

Facility's Letter of Notification received in Licensure: Yes ____ No X
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc.) approved and received in regional office: Yes ____ No ___NA
(NOTE: With exception of Initial Licensure Approvals)

Effective date: July 27, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Dr. Debra Verna/ KT 7/24/2026
Regional Administrator/Facilities Construction Director or Designee Date

Licensure Program Unit Staff 7/27/26 Date

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence, and demonstrated a commitment to providing quality patient care and services.

Medical Services of America Inc
DBA: MedXpress

Lexington, SC

is therefore granted accreditation for the following:

Home Medical Equipment

Effective: 09/28/2023

Nathan J. DeGodt
President and CEO, CHAP

COMMUNITY HEALTH ACCREDITATION PARTNER
CHAP
EST. 1965
SEAL OF ACCREDITATION

Expiration: 09/28/2026

Cordt Kassner
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www.CHAPinc.org.

Customer ID: 3008292