

ADVANCED MEDICAL SUPPLY, INC

*Alt
Maida!*

3322 N MILWAUKEE AVENUE
CHICAGO, IL 60641
PHONE: 773-205-6993
FAX: 773-205-6994



FACSIMILE TRANSMITTAL SHEET

TO:

**Doctor of patient Armando
Zavala**

FROM:

Oleg K.

FAX NUMBER:

847-934-9243

DATE:

07/21/2025

7/23/2025

RE:

**Armando Zavala
DOB 04/28/2004**

TOTAL NO. OF PAGES INCLUDING COVER:

2

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

**Please fill out attached form indicate diagnosis
related to incontinence problems, sign date and fax
back to our office with your earliest convenience.**

Please send us most recent progress notes.

Please feel free to contact our office if you have any questions at
773-205-6993.

Thank you very much for your cooperation

Sincerely, Oleg K.

THE INFORMATION CONTAINED IN THIS MESSAGE IS INTENDED ONLY FOR THE PROFESSIONAL AND CONFIDENTIAL USE OF THE DESIGNATED RECIPIENT(S). This message and/or any attachments thereto may be confidential, legally privileged, and/or exempt from disclosure under applicable law. If the reader of this message is not an intended recipient, you are hereby notified that any review, use, disclosure, dissemination, forwarding or copying of this email message and/or attachments or taking of any action in reliance on the contents therein is strictly prohibited. Please notify Advanced Medical Supply, Inc immediately by telephone or fax, and destroy the message received in error. Thank you.

Advanced Medical Supply
3322 N. Milwaukee Avenue, Chicago, IL 60641
Phone: (773) 205-6993 Fax: (773) 205-6994

DETAILED WRITTEN ORDER

Patient's Name:	ARMANDO ZAVALA	
Address:	855 E HOLLY WAY PALATINE, IL 60074	
Phone:	224-531-7828	
DOB:	04/28/2004	
Insurance Name and ID.	Medicare:	Medicaid: 315520684

Other Insurance Name and ID : MERIDIAN HEALTH PLAN INC MMCP

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PRODUCT DESCRIPTION	QUANTITY
Pull ups/Diapers	200
Liners	120
Underpads	150
Gloves	200

Height: 130 lb

Weight: 58"

Refills: 11 Refills

DIAGNOSES:

- | | | |
|---|---|--|
| <input type="checkbox"/> Stress incontinence (female) (male) | <input type="checkbox"/> Fecal smearing | <input type="checkbox"/> Emphysema/COPD/Asthma |
| <input type="checkbox"/> Urge incontinence | <input type="checkbox"/> Fecal urgency | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Incontinence without sensory awareness | <input type="checkbox"/> Full incontinence of feces | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Post-void dribbling | <input type="checkbox"/> Drug induced retention of urine | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Nocturnal enuresis | <input type="checkbox"/> Other retention of urine | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Continuous leakage | <input type="checkbox"/> Retention of urine, unspecified | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> Unspecified urinary incontinence | <input type="checkbox"/> Feeling of incomplete bladder emptying | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Mixed incontinence | <input type="checkbox"/> Generalized Body Weakness | <input type="checkbox"/> Debility |
| <input type="checkbox"/> Overflow incontinence | <input type="checkbox"/> Degenerative Osteoarthritis of _____ | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Other specified urinary incontinence | <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Incomplete defecation | <input type="checkbox"/> Organic Brain Syndrome | <input type="checkbox"/> HTN |

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

DOCTOR'S INFORMATION

Doctor's Signature: _____ Date: _____
Print Name: _____ NPI#: _____
Facility Name: _____
Address: _____
Phone: _____ Fax: _____