ADVANCED MEDICAL SUPPLY, INC

Att. 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.

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:

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