From: STL Supply

To: DR KETA Fax: 877-219-6077

Fax: +1 (972) 675-7310

Page 1 of 4 07/23/2014 10:12

1664 Larkin Williams Road . Fenton, MO 63026 p. 1-855-855-8484 f. 1-877-219-6077



To:	DR KETA	From:	O'DESHA
Fax:	972-675-7310	Date:	7/23/2014
Phone:		Page:	4 Including Cover Sheet
Re:	INCOMPLETE PAPERWORK	1	

X Action Required For Review Please Comment Please Reply Please Recycle.

***Thank you for sending back the paperwork, unfortunately one of the TXIX's is incomplete. Missing the following information(See Asterisks):

Please add the secondary DX Code and description on the attached TXIX for the incontinence supplies. You put it on one of the TXIX's but not the other.

Thanks in Advance!

***Please complete and resubmit so that we may process your request.

Comments: Fax it back to us at 1-877-219-6077. If you have difficulties with the original fax number, please use our alternate fax at 1-636-349-4440. If you have any questions, please call us at 1-855-855-8484.

Patient:	AARON JACKSON	Date of Birth:	11/23/1973
Supplies:	Incontinent Supplies		

Thank you!!! STL Medical Supply Managed Care Department

This facsimile contains information which is (a) may be LEGALLY PRIVILEGED, PROPRIETARY IN NATURE, OR OTHERWISE PROTECTED BY LAW FROM DISCLOSURE, and (b) is intended only for the use of the Addressee(s), you are hereby notified that reading, copying, or distributing this facsimile is prohibited. If you received this facsimile in error, please telephone us immediately and mail the facsimile back to us at the above address. Thank you.

From: STL Supply

To: DR KETA

Fax: +1 (972) 675-7310

Page 2 of 4 07/23/2014 10:12

Fax: 877-219-6077 nome nealth Services (Title XIX) placemedical supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, This order form cannot be accepted beyond 90 days from the date of the physician's signature.

	<u>. — . — . — . — . — . — . — . — . — . —</u>	, , ,	3								
		sted Durable Medical E mpleted by (check one):			er						
			Client	Informatio	n					*	
Client Name: JACKSON, AARON Medicaid number: 506077423 Date of birth: 11 / 23 / 1973										73	
Supplier Information											
Name: §	ST. LO	UIS MEDICAL SU	PLY	Telepho	ne: 855-	85	5-8484 Fax	numb	er: 877	-219-	6077
Address:	1664 L	ARKIN WILLIAMS	ROAD, FENTON	, MO 630	26						
TPI: 168919202 NPI: 1730109588 Taxonomy: 332B00000X Benefit Code: DM2											
QRP name: QRP TPI: QRP NPI:											
		vices being supplied und rescribed items are appro								essity a	nd
DME/medical supplies provider representative signature: Amy Gray Date: 07 / 02 / 2014											
DME/media	cal supplie	es provider representative	name (Typed or Printe	d): AMY G	RAY						
			Prescribing Ph	ysician Info	rmation						
Name: St	JMANA	КЕТНА	Telephone: 972	-675-731	.3		Fax number:	97	2-675-	-7310	
item Number	HCPCS Code	Descripti DME/medica		Quantity	Price	-	Prior authorization required?	Beyond quantity limit? ¹		Custom Item? ¹	
1	A4335	ADULT DISPOSABLE	WASHCLOTHS	2	N/A	пΥ		□Y	_y N	υΥ	χN
2	A4554	DISPOSABLE UNDER	RPADS	120	N/A	υY	₹N	пY	₹Ñ	υY	хÑ
3	A4927	GLOVES NONSTERIL	E PER 100	1	N/A	ΒY	nY nN		₹N	шY	χN
4						DY DN		пY	□ N	□Y	пN
1. If "Yes,"	additional	documentation must be p	provided to support de	termination	of medical	nece	essity.			•	
Item Number ² (From	Number ² medical necessity for requested item(s) ²										
Section A)	788	30 Urinary	inconti e	ncr							
		_									
Enter all f	tem numb	ed in Section A must have ears from the table in Section height/weight, wound st	on A that pertain to eac	h diagnosis.	A range of	item		e ente	red.		
	D-4-1	W JND	JR * 1 4*11		D.A. L.				יה אל	, <u>, .</u>	
Duration of		seen" and "Duration of ne DME: mont		Duration of			by physician: (ΧΟ / [' th (s)	7	
By signing t my signatur	his form, I e and is co	hereby attest that the information with the determination tily the prescribed items are	mation in Section "A", w ition of the client's curre	ith the except nt medical ne	tion of the L cessity and	OME p	provider's signatu cription. By press	re, wa	complete	e at the t	ime of and/or
		ation of prescribing physic		$\langle r \rangle$	lye,			te: 7		116	
-			Signature stamps	and date stan	nos ere hot	accer				' 7	
Prescribing p	ohysician'	s license number:	X 7311								· · · · · · · · · · · · · · · · · · ·
Prescribing p	shysician'	s TPI:	<u>, </u>	Prescribin	g physiciai	n's N	Pt: 1356	State	- 19	624	1478
				•			-		e_05012013/F		+ + + + + + + + + + + + + + + + + + + +

1664 Larkin Williams Road *Fenton, MO 63026 p. 1-855-855-8484 f. 1-877-219-6077



Additional information form - Incontinence Products

Patient name: <u>AARON JACI</u>	<u> (SON</u>	<u> </u>
DOB: <u>11/23/1973</u>	ID #: _	506077423
requires all incontinence supplies to be in order to approve these supplies. In o diagnostic information pertaining to the	prior author rder to sub underlying	ance for incontinence supplies. The HMO now orized and they are requiring additional information omit for authorization, we must have accurate g diagnosis/condition, as well as any other medical erall health. Please provide the following
Primary diagnosis causing inco	ntinence	: 789.30
2. Secondary diagnosis causing i	ncontine	nce: <u>344</u> . 00
3. Any additional diagnosis inform	nation:	
4. Patient current height:	5'9	
5. Patient current weight:)	13	
6. Patient approximate waist size	·	
7. Number of times per day patier らわいるる	nt to char	nge their incontinence product:
8. Quantity of each product recon	nmended	: standard
Signature of person completing: Print Name:	ANA	
Thank you again for your assistance will you have any questions, or are unable t STL Medical Supply	o complet	ter. Please fax this form back to 877-219-6077. If e this form, please contact us at 855-855-8484.

From: STL Supply Fax: 877-219-6077 To: DR KETA Fax: +1 (972) 675-7310 Page 4 of 4 07/23/2014 10:12 nome nealth Services (Title XIX) physician supplies ringsician orger rorm

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, This order form cannot be accepted beyond 90 days from the date of the physician's signature.

accepted be	york so de	ys iroin dae date of the pi	nysicium a sig	mutare.									
Section A: Requested Durable Medical Equipment and Supplies This section was completed by (check one): Requesting Physician & Supplier													
Client Information													
Client Nam	e: Jack	SON, AARON		Medicaid	numb	er: 50	607742	3	Date	of birth	: 11/2	3/1	973
Client Name: JACKSON, AARON Medicaid number: 506077423 Date of birth: 11 / 23 / 1973 Supplier Information													
Name: ST. LOUIS MEDICAL SUPPLY Telephone: 855-855-8484 Fax number: 877-219-6077													
Address: 1664 LARKIN WILLIAMS ROAD, FENTON, MO 63026													
TPI: 168919202 NPI: 1730109588 Taxonomy: 332B00000X Benefit Code: DM2													
QRP name:	QRP name: QRP TPI: QRP NPI:												
I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.													
DME/media	cal supplie	es provider representat	tive signatu	не: Оту дла	7			C)ate: 07/	02	/ 2	014	alla Park, Janus Indolesco I. of Juny 1992
DME/medi	cal supplie	es provider representat	tive name (Typed or Printe	d): A	MY G	RAY						
	***			rescribing Pl	ıysici	an Inf	ormation						
Name: \$1	JMANA	KETHA	Telep	hone: 972	-675	5-73:	13	F	ax number:	97:	2-675-	7310)
item Number	HCPCS Code		ription of dical supplic	es	Quantity		Price	Prior authorization		Beyond quantity		Custom item? ^T	
1	24402	LUBRICANT PER	OTINCE		4		N/A	ωY	required?	limit?' □Y ➡N		□Y ΩN	
2			-	TNORDET ON	-		1	ΒY	- <u>^</u> 	υY		ΒY	χN
3	MASSS	INTERMITTANT (CAIR W/.	INSERTION	2 1	5 0	N/A	пΥ	a N	ΒY	D N	σY	o N
4								υУ	n N	ΒY	□ N	ΓY	□ N
1. If "Yes," additional documentation must be provided to support determination of medical necessity,													
		*			termi	nation	ot medical	neces:	sity.				
	_	sis and Medical Ne for DME/supplies and			presc	ribina :	nhvsician.						
ltem	ICD-9		Diagnosis D	-				omplet	e justification :	for dete	rmination	of	
Number ² (From			_	-					al necessity for efer to Section			,2	
Section A)								(N	WINE TO SECTION	A, 100ti	tote i j	_	
1-2	186	30 UYINZIYY	1 inc	ontiche	L	i							
1-2	344.1		pleai										
		- C	() - () 	- \									
- "		_											
2. Each iter	n requesta	=	ave a correl	ating diagnosis	and	medica	I necessity i	iestific	ation.				
	-	ers from the table in S								e ente	red.		
If applicab	le , include	e height/weight, woun	nd stage/dir	nensions and fo	unctio	nal/mo	obility statu	S.					
Note: The "Date last seen" and "Duration of need" items <u>must</u> be filled in. Date last seen by physician; 6/20/14													
Duration of			nonth (s)				f need for s	• •			rth (s)		
By signing this form, I hereby attest that the information in Section "A", with the exception of the DME provider's signature, was complete at the time of my signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.													
Signature and attestation of prescribing physician:													
Signature stamps and date stamps are not acceptable													
Prescribing physician's license number: K 73//													
Prescribing physician's TPI: Prescribing physician's NPI: 196244 7805													
- recrining	Pillysician'	S ITE			۱۳r	escribii	ng priysicial	11.5 INP	1702	u	18	ひつ	

Effective Date_05012013/Revised Date_05012013