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

STL MEDICAL SUPPLY

To:	DR KETHA	**From:**	O'DESHA
Fax:	972-675-7310	**Date:**	7/29/2014
Phone:		**Page:**	3 INCLUDING COVER SHEET
Re:	INCOMPLETE PAPERWORK		

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

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

- **Please add the underlying DX Code that explains 'why' the patient is incontinent to the TXIX with the asterisks. The correct code (344.00) was only put on one TXIX; please put it on the other also.**

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:	INCONTINENCE SUPPLIES		

Thank you!!!

STL Medical Supply

Managed Care Department

Home Health Services (Title XIX) DME/Medical 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.

Section A: Requested Durable Medical Equipment and Supplies
This section was completed by (check one): ☐ Requesting Physician ☒ Supplier

Client Information

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 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/medical supplies provider representative signature: Amy Gray Date: 07/02/2014

DME/medical supplies provider representative name (Typed or Printed): AMY GRAY

Prescribing Physician Information

Name: SUMANA KETHA	Telephone: 972-675-7313	Fax number: 972-675-7310

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1	A4335	ADULT DISPOSABLE WASHCLOTHS	2	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
2	A4554	DISPOSABLE UNDERPADS	120	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
3	A4927	GLOVES NONSTERILE PER 100	1	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
4					☐Y ☐N	☐Y ☐N	☐Y ☐N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

Section B: Diagnosis and Medical Need Information
This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-9	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
1-3	78830	urinary incontience	
1-3	78841	urinary frequency	

****

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2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all *item numbers* from the table in Section A that pertain to each diagnosis. A range of item numbers may be entered.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status:

Note: The "Date last seen" and "Duration of need" items must be filled in. Date last seen by physician: 6/20/14

Duration of need for DME: _____ month (s) Duration of need for supplies: 99 month (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: S. Ketha Date: 7/10/14

Signature stamps and date stamps are not acceptable

Prescribing physician's license number: K 7311

Prescribing physician's TPI: Prescribing physician's NPI: ~~1356566~~ 1962467805

Home Health Services (Title XIX) DME/Medical 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.

Section A: Requested Durable Medical Equipment and Supplies
This section was completed by (check one): ☐ Requesting Physician ☒ Supplier

Client Information

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 WILLIANS ROAD, FENTON, MO 63026		
TPI: 168919202 / NPI: 1730109588	Taxonomy: 332B00000X	Benefit Code: DM2
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/medical supplies provider representative signature: Amy Gray Date: 07 / 02 / 2014

DME/medical supplies provider representative name (Typed or Printed): AMY GRAY

Prescribing Physician Information

Name: SUMANA KETHA	Telephone: 972-675-7313	Fax number: 972-675-7310

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required[1]	Beyond quantity limit?[1]	Custom item?[1]
1	A4402	LUBRICANT PER OUNCE	4	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
2	A4353	INTERMITTANT CATH W/INSERTION	S 150	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
3					☐Y ☐N	☐Y ☐N	☐Y ☐N
4					☐Y ☐N	☐Y ☐N	☐Y ☐N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

Section B: Diagnosis and Medical Need Information
This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-9	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
1-2	788.30	urinary incontience	
1-2	344.00	quadriplegia	

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all *item numbers* from the table in Section A that pertain to each diagnosis. A range of item numbers may be entered.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status:

Note: The "Date last seen" and "Duration of need" items must be filled in. Date last seen by physician: 6 / 20 / 14

Duration of need for DME: _____ month (s) Duration of need for supplies: 99 month (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: S Ketha Date: 7 / 10 / 14

Signature stamps and date stamps are not acceptable

Prescribing physician's license number: K7311

Prescribing physician's TPI: Prescribing physician's NPI: 1962447805

Effective Date_05012013/Revised Date_05012015

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STL MEDICAL SUPPLY

Additional information form – Incontinence Products

Patient name: AARON JACKSON

DOB: 11/23/1973 ID #: 506077423

Your patient has requested that we bill their insurance for incontinence supplies. The HMO now requires all incontinence supplies to be prior authorized and they are requiring additional information in order to approve these supplies. In order to submit for authorization, we must have accurate diagnostic information pertaining to the underlying diagnosis/condition, as well as any other medical diagnosis/conditions pertaining to the patient's overall health. Please provide the following information.

1. Primary diagnosis causing incontinence: 788.30
2. Secondary diagnosis causing incontinence: 344.00
3. Any additional diagnosis information: —
4. Patient current height: 5'9
5. Patient current weight: 143
6. Patient approximate waist size: _____
7. Number of times per day patient to change their incontinence product: standard
8. Quantity of each product recommended: standard

Signature of person completing: S. Ketha

Print Name: SUMANA KETHA

Doctor or Facility Name: _____

Thank you again for your assistance with this matter. Please fax this form back to 877-219-6077. If you have any questions, or are unable to complete this form, please contact us at 855-855-8484.

STL Medical Supply