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

Fax: +1 (262) 287-0804





To:	DR. SUMANA KETHA	From:	A. GRAY					
Fax:	972-675-7310	Date:	7/2/14					
Phone:	972-675-7313	Pages:	4 (Includes cover letter)					
Re:	TXIX (2); ADDITIONAL INFO LETTER							

X Action Required For Review Please Comment Please Reply Please Recycle

WE ARE CURRENTLY SUPPLYING THIS PATIENT. THIS IS FOR THEIR 6 MONTH RENEWAL.

Please provide all DX codes that apply for supplies listed. Note: If incontinence is DX Code – Please provide the incontinence code and also provide secondary DX code for underlying cause of incontinence.

PLEASE REVIEW AND SIGN THE ATTACHED FORM AS SOON AS POSSIBLE.

Comments: The following patient has requested that we bill their insurance for the medical supplies listed. In order to bill these supplies, it is required that we have a completed Physician's order form for the patient's file. Please complete the attached form in its entirety and fax it back to us at **1-877-219-6077** to ATTN: AMY GRAY. If you have difficulties with the original fax number, please use our alternate fax at **636-349-4440.** If you have any questions, please call me at **1-855-855-8484** ext: **123**.

Patient:	AARON JACKSON	Date of Birth:	11/23/1973
Supplies:	RENEWAL OF INCONTINENCE AND UR	OLOGICAL SUPP	LIES

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 MEDICAL Fax: +1 (282) 287-0804 (Title XIX) To: DR. KEHTA/PT. AAROI Fax: +1 (972) 675-7310 Page 2 of 4 07/02/2014 10:01 nome nealth Services (Title XIX) Division 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												
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: lang gray Date: 07 / 02 / 2014 DME/medical supplies provider representative name (Typed or Printed): AMY GRAY												
DIVIE/medic	cai supplie	<u> </u>										
Norman 617	77.47.373		escribing Ph	•				070		7210		
Name: St	HCPCS	KETHA Telepho Description of	one: 9/2-	-675-73 Quantity				972-675-7310 Beyond Custom				
Number	Code	DME/medical supplies		Quantity	FIRE	authorization required?		quantity limit? ¹		item? ¹		
1	A4335	ADULT DISPOSABLE WASHO	LOTHS	2	N/A	пΥ	_X N	□ Y	<u>™</u> N	пΥ	⊼N	
2	A4554	DISPOSABLE UNDERPADS		120	N/A	пΥ			₹Ñ	пΥ	⊼N	
3	A4927	GLOVES NONSTERILE PER	100	1	N/A	ΒY	χN	□ Y	₹N	пΥ	ΩN	
4					,	пY	□ N	□Y	□ N	□Ү	□ N	
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		sis and Medical Need Informat										
		for DME/supplies and must be fille		prescribing	physician.							
ltem	ICD-9	Brief Diagnosis Des	criptor		Ce	omplete	e justification f	or deter	mination	of		
Number ² medical necessity for requested item(s) ²												
	(From (Refer to Section A, footnote 1) Section A)											
(From	***************************************						efer to Section	A, footn	ote 1)			
(From		_					efer to Section	A, footn	ote 1)			
(From							efer to Section	A, footn	ote 1)			
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STL Medical Supply

To: DR. KEHTA/PT. AARO! Fax: +1 (972) 675-7310

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



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Additional information form – Incontinence Products

Patient name: <u>AARON JACKSON</u> 11/23/1973 ID #: 506077423 DOB: 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: 2. Secondary diagnosis causing incontinence: 3. Any additional diagnosis information: 4. Patient current height: _____ 5. Patient current weight: _____ 6. Patient approximate waist size: 7. Number of times per day patient to change their incontinence product: 8. Quantity of each product recommended: Signature of person completing: Print Name: 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.

From: STL MEDICAL Fax: +1 (262) 287-0804 (Title XIX) To: DR. KEHTA/PT. AAROI Fax: +1 (972) 675-7310 Page 4 of 4 07/02/2014 10:01 nome nealth Services (Title XIX) Division Supplies Physician Order Form

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DME/medical supplies provider representative signature: Amy Gray Date: 07 / 02 / 2014 DME/medical supplies provider representative name (Typed or Printed): AMY GRAY														
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Name: SUMANA KETHA Telephone: 972-675-7313 Fax number: 972-675-7310														
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						ion of								
Duration of need for DME: month (s) Duration of need for supplies: 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: Date: / /														
Signature stamps and date stamps are not acceptable														
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Prescribing :					Pres	cribin	g physicia	n's NPI	<u>-</u>					