From: STL Supply

Fax: 877-219-6077 To: DR

To: DR KETHA Fax: +1 (972) 675-7310

STL MEDICAL SUPPLY

Page 1 of 4 07/29/2014 12:41

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

To:	DR KETHA	From:	O'DESHA
Fax:	972-675-7310	Date:	7/29/2014
Phone:		Page:	3 INCLUDING COVER SHEET
Re:	INCOMPLETE PAPERWORK	1	

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

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

• 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

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.

To: DR KETHA

Fax; +1 (972) 675-7310

Page 2 of 4 07/29/2014 12:41

Fax: <u>877-219-607</u>7 nome neaRM Services (Title XIX) placemedical supplies rinysician order norm

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.

												=
		ted Durable Medical Empleted by (check one): 0			 e/							
		- -		Information							-	1
Client Nam	a: JACK	SON, AARON		number: 50		3	Date o	of birth:	11/	23/1	973	1
				r informatio		_						1
Name: S	er to	UIS MEDICAL SUP				220.	-8484 Fax	aumher	· 97	7-219	-6077	1
		ARKIN WILLIAMS				627	-6464 104	18017 8201	. 13 /	1-213	0077	İ
	589192			ny: 332B0			Benef	it Code:	DM2	···· - ·-		
QRP name:				RP TPI:			QRP					
		vices being supplied und rescribed items are appro					determination	of med			and	
ļ.:		es provider representative :			IR (IRBIT)	······································	Date: 07/	ο μι σ ου 02		2014		
	-	es provider representative r		 	PAY	L	Date, G/?	V <u>Z</u>		2013		i
DITECTIFICANT	res authbre	- Projuci ichicacimerei	Prescribing Ph									1
Manual Pr	TEAN TR	AE&A 9	Telephone: 972-			Т	Fax number:	อาว		5-731({
Name: SQ Item	HCPCS	KETHA Description		Geantity Quantity	2 Price		Prior	1	ond		ustom	ł
Number	Code	DME/medical		*	: 117-W	3	rion required?	qua	ntity ntity nit?"		tent?"	
1	A4335	ADULT DISPOSABLE	washcloths	2	N/A	пΥ		<u> </u>	₹N	υY		
2	A4554	DISPOSABLE UNDER	PADS	120	N/A	ΩY	<u>~~</u>		₹N	DΥ	χN	
3	A4927	GLOVES NONSTERLL	e per 100	1	N/A	ρY	<i>A</i> .	<u> </u>	ì	α¥	χN	
4						пY	αN	۵Y	ΒN	σ¥	n N	
1. If "Yes,"	additiona	documentation must be p	orovided to support de	termination o	of medical	nece	ssity.					
This is a pro- item Number ² (From	escription ICD-S	o for DME/supplies and mu Brief Diag	st be filled out by the nosis Descriptor	prescribing p	C	medi	ete justification i cal necessity for Refer to Section	requeste	d iten			
Section A) 1 - 2	768	30 Urinary	inconti e	ncr								
1-3	798		+	20/01/			**************************************				***************************************	
1-1	1/12/	WITH TAILY	— W CAPAC	DLY_								**************************************
V			**************************************			-A		······································			yy wannin	i
	<u> </u>		# _4 # *			······································		#		***************************************		4
	•	ed in Section A must have a hers from the table in Section						sa antor	ari			
		bers from the table in Section e height/weight, wound st					numbers may t	a chier	Zi.	·		ł
ու ոֆ հատան	arug serus wind	o saugise mugily stease se	nggay waa i tuu i 1847 22 43 (U-C)	ery - Nabelsel - PAGE (F T T TAU	menting westernia							
Nain The	Mata t	seen" and "Duration of ne	ari itarra mush L. E.	nd in	Date lart	1087	by physician:	0 /-	<u>() </u>	IU	-	1
Duration of				Duration of			13.13	mont		17		1
By signing t	his form,	hereby attest that the infor	mation in Section "A", w	ith the except	tion of the	DME	rovider's signat	ure, wal	compl			1
		onsistent with the determinantify the prescribed items are			-	-		_		ikriesi Pa	nc. 6 47/3/101	
Signature a	and attest	ation of prescribing physic	ian:	<u>\"L</u>	Wly.		Da	ate: 7	110	114	l	1
			Signature stamps	and date stan	n hã ere not	acce	otable			,		_
Prescribing	physician	's license number:	K 7311									1
Prescribing	physician	's TPI:	`	Prescribin	g physicla	n's N		Val.	$\overline{}$		4478	d 5
		_	_					Keriko Dato	0.0120	Deswer(E)	uc_05012013	

Fax: 877-219-6077
To: DR KETHA
Fax: +1 (972) 675-7310
nome nealth Services (Title XIX) pluc/wiedical supplies r'nysician order rorm

(2) 675-7310 Page 3 of 4 07/29/2014 12:41

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												
			Supplie	r Informati	ion							
Name: 5	T. LOUI	S MEDICAL SUP	PLY	Teleph	one: 855-	855-1	484 Fax	numbe	es 877-	219	6077	
Address: 1	664 LAR	KIN WILLIAMS	ROAD, FENTON	MO 63	026		,					
TPI: 1	68919202	NPI: 17301	L09588 Taxonon	ny: 332B	X00000		Benef	it Code	DM2			
QRP name:												
,		es being supplied und cribed items are appro								ssity a	nd	
		rovider representative :		******************	(Inc. (Inc. I)	Da	······································	02	****	14		
		rovider representative i			RAY							
	rat actiferate b	the state of the s	Prescribing Ph									
Namer St	JMANA KE		Telephone: 972-	-		Fa	cnumber:	971	2-675-	7310		
İtem	HCPCS	Description		Quantity	Price	,	Prior	_	eyond	Custom		
Number	Code	DME/medical					orization quired1		iantity mit?	ltern?™		
1	A4402 L	JERICANT PER OU	NCE	4	N/A		AN An	υ γ	Ż.	пγ	ŖΝ	
		TERMITTANT CAT			N/A	Ω¥	<u>-</u> 닷N	ΠY	XN	αΥ	ЯN	
3						αY	αN	ΠY	αN	σY	oN	
4	y -,			estrativ	•	αY	αN	υY	αN	сY	пN	
1. If "Yes,"	If "Yes," additional documentation must be provided to support determination of medical necessity.											
Section B	: Diagnosis	and Medical Need (nformation			,			·			
This is a pro	escription fo	r DME/supplies and mu	ist be filled out by the	prescribing	physician.							
Itam Number ¹ (From Section A)	er ¹ medical necessity for requested Rem(s) ² (Refec to Section A, footnote 1)											
1-2	786.30	HYMAKV	inconticho	e				**************************************		***		
1-2	344.00		eaia	· · · · · · · · · · · · · · · · · · ·				•••••••••••••••••••••••••••••••••••••••		STANDARD STANDARD STANDARD	a kinana kinana kinana kinana	
	12 Pita Many it (C), or									······································		
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.												
								na anta	rad	***************************************		
Enter all I	tem numbers	from the table in Section	on A that pertain to eac	ch diagnosis	. A range of	item nu		oe ente	red.			
Enter all I	tem numbers		on A that pertain to eac	ch diagnosis	. A range of	item nu		e ente	red.	***************************************		
Enter all I	tem numbers	from the table in Section	on A that pertain to eac	ch diagnosis	. A range of	item nu		e ente	red.			
Enter all I	tem numbers	from the table in Section	on A that pertain to eac	ch diagnosis	. A range of	item nu		be ente	red.	***************************************		
Enter all I	tem numbers	from the table in Section	on A that pertain to eac	ch diagnosis	. A range of	item nu		≫ ente	red.			
Enter all I	item numbers Ie, include h	from the table in Section	on A that pertain to eac age/dimensions and fo	ch diagnosis unctional/m	i. A range of obility statu	item nu s:		be ente	267 J	Ч		
Enter all J If applicab	item numbers Ie, include h	from the table in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Section in Sec	on A that pertain to ear age/dimensions and fu age/dimensions and fu sed "Items <u>must</u> be filli	ch diagnosis unctional/mi	i. A range of obility statu	item nu s: seen by	mbers may l	010	761 1th (s)	Ч		
Enter all / If applicab Note: The ' Duration of By signing 1	item numbers ile, include h Date last set f need for Di this form, the	from the table in Section eight/weight, wound sta en" and "Duration of ne IE:mont	on A that pertain to ear age/dimensions and for sed "Items <u>must</u> be fille th (s) mation in Section "A", w	ch diagnosis unctional/m ed in. Duration c	Date last	item nu s: seen by upplies: DME pro	physician; (mon	261 th (s)			
Enter all / If applicab Note: The " Duration of By signing try signature	item numbers ile, include h include	from the table in Section eight/weight, wound sta err and "Duration of ne	on A that pertain to ear age/dimensions and for sed "Items <u>must</u> be fille th (s) mation in Section "A", wation of the Client's curre	ch diagnosis unctional/m ed in. Duration c etch the excep	Date last: Freed for species of the last:	item nu s: seen by upplies: DME proscrip	physician; (Of rider's signation. By pres	mon wre, was	2611 th (s) s complete the identif			
Enter all / If applicab Note: The ' Duration of By signing 1 my signatur medical sur	tem numbers Ile, include h Date last set f need for DA this form, the re and is cons pplies, I certify	from the table in Section eight/weight, wound state en" and "Duration of me it:	on A that pertain to ear age/dimensions and for eed "Items <u>must</u> be fille th (s) mation in Section "A", w ation of the client's curre e appropriate and can se	ch diagnosis unctional/m ed in. Duration c etch the excep	Date last: Freed for species of the last:	item nu s: seen by upplies: DME proscrip	ohysician; (//der's signat tion. By pres when used as	mon wre, was	2611 th (s) s complete the identif			
Enter all / If applicab Note: The ' Duration of By signing 1 my signatur medical sur	tem numbers Ile, include h Date last set f need for DA this form, the re and is cons pplies, I certify	from the table in Section eight/weight, wound state err" and "Duration of ne AE:mont reby attest that the inform istent with the determina- of the prescribed items are	on A that pertain to ear age/dimensions and for eed "Items <u>must</u> be fille th (s) mation in Section "A", w ation of the client's curre e appropriate and can se	ch diagnosis unctional/m ed in. Duration c eith the excel ent medical r efel r byused	Date last: of need for sprion of the linecessity and in the client	item nu s: seen by upplies: DME proi f prescrip 's home	physician; (// / //der's signation. By pres when used as	mon wre, was cribing	2611 th (s) s complete the identif			
Enter all / If applicab Note: The " Duration of the signature of the sig	tem numbers le, include h Date last see f need for Dh this form, the re and is cons opties, i certify and attestation	from the table in Section eight/weight, wound state err" and "Duration of ne AE:mont reby attest that the inform istent with the determina- of the prescribed items are	on A that pertain to ear age/dimensions and for sed "Items <u>must</u> be fille th (s) mation in Section "A", we ation of the client's curre e appropriate and can se ian:	ch diagnosis unctional/m ed in. Duration c eith the excel ent medical r efel r byused	Date last: of need for sprion of the linecessity and in the client	item nu s: seen by upplies: DME proi f prescrip 's home	physician; (// / //der's signation. By pres when used as	mon wre, was cribing	2611 th (s) s complete the identif			

Effective Date_05012013/Revised Date_05012015

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 JACKSON</u>							
DOB: <u>11/23/1973</u> ID #: <u>506077423</u>							
Your patient has requested that we bill their insurance for incontinence supprequires all incontinence supplies to be prior authorized and they are requiring in order to approve these supplies. In order to submit for authorization, we rediagnostic information pertaining to the underlying diagnosis/condition, as we diagnosis/conditions pertaining to the patient's overall health. Please providinformation.	ing additional information nust have accurate reliated as any other medical						
1. Primary diagnosis causing incontinence:							
2. Secondary diagnosis causing incontinence: <u>344.06</u>							
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:						
8. Quantity of each product recommended: 5thndhr.	<u>d</u>						
Signature of person completing:							
Print Name: SOMANA 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.