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:	7/14/2014
Phone:		Page:	4 INCLUDING COVER SHEET
Re:	INCOMPLETE PAPERWORK		

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

***Thank you for sending back the TXIX(s) and AIL forms, <u>unfortunately the</u> paperwork is incomplete. <u>Missing the following information:</u>

 Add the underlying DX Code for the 'cause or why' the patient is incontinent on the TXIX (see asterisks).

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 AND UROLOGICA	L 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.

nome nealth Services (Little XIX) plyic/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.

	•		able Medical by (check one):			•	er							
		-		·	Client	Information	n						-	1
Client Nam	ne: JACK	SON.	AARON		Medicaid	number: 50	607742	3	D	ate of birth	11/	23/1	973	
			-		Supplie	r Informatio	on			-				
Name:	ST. LO	UIS M	EDICAL SU	PPLY				855-	8484	Fax numb	er: 877	-219	-6077	1
		-	WILLIAMS		FENTON									1
•	689192			109588		ny: 332B0			В	enefit Code	: DM2]
QRP name	:				Q	RP TPI:				QRP NPI:				
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DME/medi	ical supplie	es provide	er representative	e signature:	any Gra	ザ		D	ate: 0	7/ 02	/ 2	014]
DME/medi	ical supplic	es provide	er representative	e name (Typ	ed or Printe	d): AMY G	RAY]
				Pre	scribing Pl	ysician Info	rmation]
Name: S	UMANA	KETHA	·	Telepho	ne: 972	-675-731	.3	F	ax numbe	er: 97	2-675	-7310)]
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2	A4554	DISPO	SABLE UNDE	RPADS		120	N/A	υY	ХN	ДΥ	₹N	υY	хN	
3	A4927	GLOVE	S NONSTERI	LE PER I	100	1	N/A	ŋΥ	χN	ΩY	₹N	αY	χN	1
4								пY	□N	υY	□ N	п¥	οN]
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This is a pr	escription	o for DMF	dermultan and m	L . 20										1
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	_		able Medical l by (check one):			•	er					_	
					Client	Informatio	n						
Client Name	: JACK	SON,	AARON		Medicaid	number: 50	607742	3	Date	of birth	11/:	23/19	73
					Supplie	r Informati	on						
			EDICAL SU				ne: 855-	855	-8484 Fax	numb	s: 877	-219-	6077
			WILLIAMS										
	89192	02	NPI: 1730	109588		ny: 332B(00000x				DM2		
QRP name:	t the car	vicas kai	ng supplied un	derthic av		RP TPI:	the shucid	inn'e s		NPI:	dical nov	nerity a	nd l
			items are appr									езыцу а	nu
DME/medic	al supplie	s provide	er representative	e signature:	any gra	7			Date: 07 /	02	/ 2	014	
DME/medic	al supplie	es provide	er representative	name (Typ	ed or Printe	d): AMY G	RAY						
				Pre	scribing Pl	ysician Info	rmation						
Name: St		KETHA			ne: 972·	-675-731	1		Fax number:	_	2-675		
ltem Number	HCPCS Code		Descript DME/medica			Quantity	Price	24	Prior uthorization required?	qı	eyond antity mit? ¹		stom em? ¹
1	A4 335	ADULT	DISPOSABL	E WASHC	LOTHS	2	N/A	пΥ		υY	₹N	υΥ	χN
2	A4554	DISPO	SABLE UNDE	RPADS		120	N/A	υY	₹N	пΥ	ħN	υY	хÑ
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	_	for DME	Medical Need <u>/supplies and m</u> Brief Dia		out by the	prescribing j	C	medic	ite justification al necessity for Refer to Section	request	ed item(s		
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1-2	780		(1\17\1)	the	dian				•				
<u> </u>	1.00-		<u> </u>		4000	- 							
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If applicab	ie, in cludo	e height/1	weight, wound s	stage/dimer	nsions and fi	unctional/mc	bility statu	S:					
Note: The "	Date last	seen" an	d "Duration of n	need" items	must be fill	ed in.	Date last:	seen t	oy physician:	0/0	20 / 1	4	
Duration of	need for	DME:	mor	nth (s)	_	Duration o	L	~	73.71		ith (s)	<u> </u>	
By signing t my signatur	his form, l	hereby at	ttest that the info with the determin rescribed items a	ormation in S nation of the	client's curr	with the excep ent medical n	tion of the l ecessity and	DME p	rovider's signat ription. By pres	cribing	the ident		
Signature a	nd attest	ation of p	rescribing physi	ician:		<u>\</u> '\'	We.		D	ate: 7	110	114	
				Sign	eture stamps	s and date sta	mps ore not	accep	table			7	
Prescribing	physician	's license	number:	R	7311								

nome nealth Setvices (Title XIX) plyc/wedicai Supplies r'nysicián 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.

	: Requested n was compl							ıpplie	er										
						Client	Inform	ation											
Client Name	z Jackso	N, 2	AARON			Medicaid	number	: 506	507742	3		Date o	f birth	11	/ 23	3 / 19	73		
•		-				Supplie	r Infor	natio	n										
Name: §	ST. LOUI	S ME	EDICA	L SUP	PLY		Tel	ephor	ne: 855 -	855-	-848	4 Fax	numbe	er B	77-	219-	6077		
Address: 1	1664 LAR	KIN	WILL	IAMS I	ROAD,	FENTON	, MO	630	26										
TPI: 10	68919202	!	NPI;	17301	09588	Taxonor	ny: 33	2B0	0000X			Benefi	t Code	DM	12				
QRP name:						Q	RP TPI:					QRP	NPI:						
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DME/medic	cal supplies p	rovide	r repress	entative s	signature:	any Gra	7			Ĺ)ate:	07/	02	/	20	14			
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					Pre	escribing Pl	ysician	Info	rmation										
Name: St	JMANA KE	THA			Telepho	one: 972	-675-	731	3	F	ax nur	nber:	97:	2-67	75-7	7310			
ltem Number	HCPCS Code			Descriptio E/medical			Quantity Price				Prior authorization required?			Beyond quantity limit?			Custom item? [*]		
1	A4402 LU	BRIC	CANT E	ER OU	NCE		4		N/A	ΠY	§N		υY	₹N		ΠY	χN		
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