1664 Larkin Williams Road · Fenton, MO 63026
p. 1-888-613-8688
f. 1-800-988-0199

STL MEDICAL SUPPLY

Fax

To:	DR KETHA SUMANA	**From:**	STEPHANIE SCOTT
Fax:	972-675-7310	**Date:**	1/22/2014
Phone:	972-675-7313	**Page:**	*3* *Includes cover sheet*
Re:	TITLE XIX		

x Action Required For Review Please Comment Please Reply Please Recycle

PLEASE INCLUDE PRIMARY AND SECONDARY DIAGNOSIS FOR THE CAUSE OF INCONTINENCE*

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 **1-800-988-0199** to **ATTN STEPHANIE SCOTT**. 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 UROLOGICAL SUPPLIES**		

Thank you –

STEPHANIE SCOTT
STL Medical Supply Managed Care Department
855-855-8484 x 155 (p) 800-988-0199 (f)

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: Stephanie Scott Date: 01 / 22 / 2014

DME/medical supplies provider representative name (Typed or Printed): STEPHANIE SCOTT

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	A4927	GLOVES NONSTERILE PER 100	2	N/A	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☒ N
2	A4554	DISPOSABLE UNDERPADS	150	N/A	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☒ N
3	A4335	ADULT DISPOSABLE WASHCLOTHS	5	N/A	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☒ N
4	A4335	PERINEAL WASH	2	N/A	☐ 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)
	___.__		
	___.__		
	___.__		
	___.__		

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: / /
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

Prescribing physician's license number:

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

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: Stephanie Scott Date: 01 / 22 / 2014

DME/medical supplies provider representative name (Typed or Printed): STEPHANIE SCOTT

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	A4402	LUBRICANT PER OUNCE	8	N/A	☐Y ☒N	☐Y ☒N	☐Y ☒N
2	A4353	INTERMITTANT CATH W/INSERTION	180	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)
	___.__		
	___.__		
	___.__		
	___.__		

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: / /
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

Prescribing physician's license number:

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