From: STL Supply

Fax: 877-219-6077

To: DR KETHA

Fax: +1 (972) 675-7310

Page 1 of 4 07/14/2014 2:41

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:	7/14/2014
Phone:		Page:	4 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(s) and AIL forms, <u>unfortunately the paperwork is incomplete</u>. <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.

From: STL Supply

To: DR KETHA

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Page 2 of 4 07/14/2014 2:41

Fax: 877-219-6077

nome nealth Services (Title XIX) placemedical 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

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						questing Phys		lier							
						Clie	nt Informatio	on .							1
	Client Nam	e: JACK	SON, J	ON , AARON Medicaid number: 506077423 Date of birth: 11 / 23 / 1973											
			Supplier Information								1				
	Name:	ST. LO	JIS ME	EDICAL S	UPPLY		Teleph	one: 855-	855	-8484	Fax numb	per: 87 '	7-219	-6077	
	Address:	1664 L	ARKIN	WILLIAM	S ROA	D, FENTO									1
	TPI: 1	689192	02	NPI: 173	01095	88 Taxon	omy: 332B	X00000		В	enefit Cod	e: D M 2			
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Effective Date_05012013/Revised Date_05012013

To: DR KETHA

Fax: +1 (972) 675-7310

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Fax: 877-219-6077 nome nealth Services (Title XIX) placemedical 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.

'		.,											
				quipment and Sup		ier							
				Client	Informatio	n					**		
Client Nam	Elient Name: JACKSON, AARON Medicaid number: 506077423 Date of birth: 11/23/1973											73	
		,		<u> </u>	r Informati		_						
Name: 5	ST. IO	UTS ME	DICAL SUP				. R S	5-8484 Fax	numbe	er: 877	_210-	. 6077	
				ROAD, FENTON,			UJ	7-0404 tax	TICH, NO	0//	-215	0077	
	689192				ny: 332B(Benefi	t Code	: DM2			
QRP name:					RP TPI:			QRP					
l certify th	at the ser	vices bein	g supplied and	er this order are cons	sistent with	the physic	ian's	determination	of me	dical nec	essity a	nd	
prescription	n, The p	rescribed i	items are appro	priate and can safely	be used in t	the client's	s ho	ne when used a	s presi	ribed.			
		OFFICE AND ADDRESS OF THE PARTY	, . r	signature: Amy Gra	<i>-</i>			Date: 07 /	02	/ 2	014		
DME/medi	cal supplie	es provider	representative r	name (Typed or Printe	d): AMY G	RAY							
	•			Prescribing Ph	ysician Info	ormation							
Name: St		KETHA			-675-731	13		Fax number:	972	2-675	-7310	0	
item Number	HCPCS Code	Description of DME/medical supplies			Quantity	Price	,	Prior authorization required?	Beyond quantity limit? ¹			stom em? ¹	
1	A4335	ADULT	DISPOSABLE	WASHCLOTHS	2	N/A	ים		пY	• y N	υΥ	χN	
2	A4554	DISPOS	ABLE UNDER	PADS	120	N/A	ים	/ ½N	ΔY	₹N	υY	χN	
3			NONSTERIL		1	N/A	ים		ΩY	<u>"</u> N	ΠY	ΩN	
4				·		,	ים	/ _N	σY	□ N	□Y	n N	
1 If "Yes ":	additional	i documen	tation must be n	rovided to support de	termination	of medical	nece	accitu			_l.		
Number ² (From Section A)			_	·			med	lete justification f ical necessity for a (Refer to Section)	request	ed item(s			
1-3	788	30 U	YINZYY	inconti e	ence								
	<u> </u>	_		·									
		_											
2. Each iter	n regueste	ed in Section	on A must have a	correlating diagnosis	and medical	necessity i	justif	ication.					
				n A that pertain to eac					e ente	red.			
lf applicab	le, include	e height/w	eight, wound sta	ige/dimensions and fu	inctional/mo	bility statu	5:						
										_			
Note: The "	Date last	seen" and	"Duration of ne	ed" items <u>must</u> be fille	ed in.	Date last:	seen	by physician: (010	20/1	9		
Duration of	need for	DME	month	n (s)	Duration of	need for s	uppl	ies: 99	_ mon	th (s)	-		
my signatur	e and is co	nsistent wi	th the determina	nation in Section "A", w tion of the client's curre appropriate and can sa	ent medical ne	ecessity and	pres	cription. By prese	ribing	the identi	e at the t fied DMI	ime of and/or	
			scribing physici		<.r	eles.		_	te: 7	110	114		
				Signature stamps	ariti date stan	m ps are not	acce	ptable					
rescribing p	ohysician'	s license n	umber:	-K 7311									
rescribing p	shysician'	s TPI:		,	Prescribin	g physiciai	n's N	PI: 1356	State	- 19	620	1478	
			,					Elf	ective Dat	e_05012013/1	Revised Date	2_ 05012 013	

Fax: 877-219-6077 To: DR KETHA Fax: +1 (972) 675-7310 Parome nealth Services (Title XIX) Divic/wiedical supplies rinysician Order rorm Page 4 of 4 07/14/2014 2:41

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 Nam	Medicaid number: 506077423 Date of birth: 11 / 23 / 1973													
			Suppl	ier Infor	mati	on		•						
Supplier Information Name: ST. LOUIS MEDICAL SUPPLY Telephone: 855-855-8484 Fax number: 877-219-6077												7		
Address: 1564 LARKIN WILLIAMS ROAD, FENTON, MO 63026											Τ			
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.												dialogue.		
DME/medical supplies provider representative signature: Umy Gray Date: 07 / 02 / 2014 DME/medical supplies provider representative name (Typed or Printed): AMY GRAY														
DME/medic	cal supplies pr	rovider representative i											_	
			Prescribing F										_	
	JMANA KE		<u> </u>	2-675				Fax number:	972-675-7310					
item Number	HCPCS Code	Description DME/medical		Quar	ntity	Price		Prior uthorization required?	qu	eyond :antity imit?"	_	Custom item? [†]		
1	A4402 LU	BRICANT PER OU	NCE	4		N/A	ΒY	₹N	υY	₹N	пΥ	χN	_	
2	A4353 IN	TERMITTANT CAT	H W/INSERTION	s 15	0	N/A	ΒY	₹N	υY	χÑ	пΥ	χN	_	
3						,	пΥ	Ω N	υY	□ N	ΩY	ΩN	_	
4				+		<u> </u>	шY	□ N	ΒY	□Ñ	ΓŸ	пN	_	
1. If "Yes."	l additional doc	cumentation must be p	provided to sugnort a	determin	ation	of medical	neces	sity.					_	
		and Medical Need I			4000	o, medicai							_	
	_	DME/supplies and mu		e prescri	bing _l	physician.								
I tem Number ² (From Section A)	ICD-9	Brief Diag	nosis Descriptor			Complete justification for determination of medical necessity for requested item(s) ² (Refer to Section A, footnote 1)								
1-2	186.30	VAILUSIAN	Incontien	U.						· - ·			_	
1-2	344.00	avadrible	aia	-						•				
		C T	- 											
	'-												_	
	=	n Section A must have a from the table in Section							e ente	red.	_			
								,						
If applicable, include height/weight, wound stage/dimensions and functional/mobility status:														
Note: The "	Date last seer	n" and "Duration of ne	ed" items <u>must</u> be fil	lled in.		Date last :	seen b	y physician; (01	2011	4			
Duration of	need for DMI	E:mont	h (s)	Durat	ion o	r f need for s	upplie	s: 00	non	nth (s)				
my signatui	e and is consis	eby attest that the informatent with the determinanthe prescribed items are	tion of the client's cur	rent med	lical no	ecessity and	presc	ription. By pres	cribing	the identi				
		n of prescribing physici		5	(le	AG _		Da		110	1/1	, +		
			Signature stamp	s and da	te star	mpsare not	accept	table						
Prescribing	Prescribing physician's license number: $K73/I$													
Prescribing physician's TPI: Prescribing physician's NPI: 196244 7805														

Effective Date_05012013/Revised Date_05012013