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

To:





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 UROLOGIC	CAL SUPPLIES	

Thank you -

STEPHANIE SCOTT

STL Medical Supply Managed Care Department

855-855-8484 x 155 (p) 800-988-0199 (f)

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: CLAUDINE J Fax: +1 (262) 287-0804 (Title XIX) To: Page 2 of 3 02/05/2014 4:24

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.

	_	sted Durable Medical Ed mpleted by (check one):			ınnlis	or.							
THIS SECTION	ii was cui	impleted by (check one).											
Client Information  Client Name: JACKSON, AARON  Medicaid number: 506077423  Date of birth: 11 / 23 / 1973													
Cherieriani	c. 5/10/1		Supplie							11 / 23	, 10		
Name: §	T. LOU	IS MEDICAL SUPPLY		- 1		ne: 855-	855-8	484 Fax	numbe	er: 877-2	19-60	177	
			, FENTON, MO 6			333	000 0			<u> </u>			
Address:         1664 LARKIN WILLIAMS ROAD, FENTON, MO 63026           TPI:         168919202         NPI:         1730109588         Taxonomy:         332B00000X         Benefit Code:         DM2													
QRP name: QRP TPI: QRP NPI:													
		vices being supplied underescribed items are approp									ssity a	nd	
DME/medical supplies provider representative signature: Stephanic Scott Date: 01 / 22 / 2014													
DME/medical supplies provider representative name (Typed or Printed): STEPHANIE SCOTT													
			Prescribing Ph	ıysician	Info	rmation							
Name: SUMANA KETHA Telephone: 972-675-7313 Fax number: 972-675-7310													
lt <del>e</del> m Number	HCPCS Code	D <del>e</del> scriptio DME/medical		Quant	tity	Price	Prior authorization		Beyond quantity		Custom item? <sup>†</sup>		
1	A4927	GLOVES NONSTERILE	DER 100	2		N/A	required? □Y syN		limit?¹ □ Y SyN		□Y XN		
2	A4554	DISPOSABLE UNDERPA		150		N/A	□Y		□ <b>Y</b>	 SkN	□Y		
3	A4335			5			ΒY			 SyN	пΥ	· XN	
4			ASHCLUTHS			N/A	□Y S <sub>Z</sub> N		ωY	_^ <sub>□</sub> N	□Ÿ	N	
1 If "Vas "	4 A4335 PERINEAL WASH 2 N/A PY N PY N  1. If "Yes," additional documentation must be provided to support determination of medical necessity.												
		sis and Medical Need Ir		termina	itioni	ormedical	Hecess	orty.					
	_	ofor DME/supplies and mus		prescrib	ing p	hysician.							
Item Number <sup>2</sup> (From Section A)	Item ICD-9 Brief Diagnosis Descriptor Number <sup>2</sup> (From					Complete justification for determination of medical necessity for requested item(s) <sup>2</sup> (Refer to Section A, footnote 1)							
		_											
		_											
		_											
	•	ed in Section A must have a											
		pers from the table in Section e height/weight, wound sta	-					iumbers may i	e ente	reu.			
паррисал	<b>L</b> , merde	e reigite vergite voord sta	<b>3</b> 0 and 130 12 and 10			only states.	<i>.</i>						
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	n (5)	Durati	on of	need for su	upplie	s:	_ mon	ith (s)			
my signatur	e and is co	hereby attest that the inform onsistent with the determinat tify the prescribed items are	tion of the client's curre	ent medi	cal ne	ecessity and	prescr	iption. By pres	cribing	the identif			
Signature a	nd attesta	ation of prescribing physicia	en:					Da	ite:	/	/		
			Signature stamps	and date	e stan	nps are not	accept	able					
Prescribina :	ohysician'	's license number:											
	ohysician'			Pres	cribin	ıg physiciar	n's NPI	<u> </u>					

From: CLAUDINE J Fax: +1 (262) 287-0804 (Title XIX) To: Page 3 of 3 02/05/2014 4:24

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.

	_	sted Durable Medical E			pplie	er										
		•		Informa	-											
Client Name: JACKSON, AARON Medicaid number: 506077423 Date of birth: 11 / 23 / 1973																
			Supplie	r Inforn	natio	on		•								
Name: §	T. LOU	IS MEDICAL SUPPLY		Tele	pho	ne: 855-	855-8	484 Fax	numb	er: 877-2	19-60	)77				
Address: 1	664 LAI	RKIN WILLIAMS ROAI	T'													
TPI: 168919202 NPI: 1730109588 Taxonomy: 332B00000X Benefit Code: DM2																
QRP name:				RP TPI:	7.1 .			QRP			1.					
		vices being supplied und rescribed items are appro									ssity a	ind				
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 aignature. Supplies Date: 017 22 7 2014  DME/medical supplies provider representative name (Typed or Printed): STEPHANIE SCOTT																
			Prescribing Pl	nysician	Info	rmation										
Name: SUMANA KETHA Telephone: 972-675-7313 Fax number: 972-675-7310																
ltem Number	HCPCS Code	Descripti DME/medical		Quant	Quantity		Prior authorization		Beyond quantity		Custom item? <sup>†</sup>					
1							_ r	equired? sχN	□ Y	imit?¹ ⊠xN	□Y <sub>X</sub> N					
2	A4402	LUBRICANT PER OUN		8		N/A	ΒY		пΥ	X'' SkN	□ Y					
	A4353	INTERMITTANT CATH	W/INSERTION	180		N/A	DΥ	ÿN □N	пΥ	יא. ח N	пΥ	XN □N				
3																
4							пY	□ N	□ <b>Y</b>	□ N		□N				
		documentation must be p		etermina	tion (	of medical	necess	sity,								
	_	sis and Medical Need I for DME/supplies and mu		nrescrih	ina n	hvsician										
This is a prescription for DME/supplies and must be filled out by the prescribing physician.  Item ICD-9 Brief Diagnosis Descriptor Complete justification for Mumber <sup>2</sup> (From Section A)  Section A)						or requested item(s) <sup>2</sup>										
		_														
	ļ·	_														
<b>2.</b> Each iter	n request	=   ed in Section A must have a	a correlating diagnosis	and me	dical	necessity j	ustifica	ation,								
Enter all I	tem numb	pers from the table in Section	on A that pertain to ea	ch diagn	osis.	A range of	item n	umbers may l	e ente	red.						
It applicab	<b>ie</b> , includ	e height/weight, wound st	age/dimensions and fi	unctio <b>na</b>	I/mo	bility statu:	S:									
A[	D-4- 14				······································	Data last		u a la val d'a a .	/	<i>f</i>		***************************************				
Note: The "Date last seen" and "Duration of need" items <u>must</u> be filled in.  Duration of need for DME: month (s) Duration						Date last seen by physician: / / ion of need for supplies: month (s)										
By signing t my signatur	his form, I e and is co	hereby attest that the informal the informal the informal the determination the prescribed items are	nation in Section "A", v tion of the client's curre	vith the e ent medic	xcept al ne	tion of the E ecessity and	OME proper	ovider's signat iption. By pres	ure, wa cribing	s complete the identif						
_		ation of prescribing physici							ite:	/	/					
-		. 3.7	Signature stamps	and date	stan	nps are not	accept	able								
Prescribing r	hveician'	s license number:														
		o meetide tidiiIMeli														