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) |
|---|---|---|---|
| 1-4 | 788.30 | urinary incontinence | |
| 1-4 | 344.00 | quadriplegia | |
| | ___.- | | |
| | ___.- | | |

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: 8/11/2014 |
|---|---|
| Duration of need for DME: _____ month (s) | Duration of need for supplies: 99 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: 8/11/14

**Signature stamps and date stamps are not acceptable**

Prescribing physician's license number: K7311

| Prescribing physician's TPI: | Prescribing physician's NPI: 1962447805 |
|---|---|

# 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) |
|---|---|---|---|
| 1-4 | 344.00 | quadriplegia | |
| | ___.__ | | |
| | ___.__ | | |
| | ___.__ | | |

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: 8 / 11 / 14

Duration of need for DME: _____ month (s) Duration of need for supplies: 99 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: S-Kethe Date: 8 / 11 / 14

**Signature stamps and date stamps are not acceptable**

Prescribing physician's license number: K7311

Prescribing physician's TPI: Prescribing physician's NPI: 1962447805