PROVIDER
DME/Supply Referral Form

Contact STL Medical Supply

Phone: 855-855-8484 – **Fax:** 877-219-6077 – **Email:** CoordinatedCare@stlmedical.com

Referring Information:

Referring Name: _____ Referring Company: _____

Referring Contact Phone #: _____ Referring Email: _____

Member Information:

Name: _____ Phone #: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Medicaid #: _____ Date of Birth: _____

Diagnosis Code(s): _____

Alt. Contact Name: _____ Alt. Contact Phone #: _____

Alt. Contact Relation: _____

Physician Information:

Referring Physician: _____ NPI (optional): _____

Physician Contact Phone #: _____ Physician Fax #: _____

DME / Medical Supply Information (Please be as detailed as possible):

Physician Signature: _____ **Date:** _____