VITAL HEALTH SERVICES, LLC
Vital Health Home Care | 7048 Knightdale Blvd., Suite 101, Knightdale, NC 27545 | Phone (919) 679-3022 | Fax (888) 398-8099

Vital Health Home Care - Case Manager & Provider Referral

Blank printable office copy. Complete only sections that apply. Attach supporting records separately.

Privacy and coverage notice: Do not email protected health information through ordinary email. Submission does not guarantee coverage, authorization, employment, service availability, or fulfillment. Payer policy and product-specific requirements control. Call 911 for emergencies.

Referral Source & Authorization	_____
Referrer full name	_____
Professional title / role	_____
Organization	_____
Phone number	_____
Fax number	_____
Email address	_____
Relationship to person being referred	_____
Organization type	☐ _____ ☐ Other: _____
Authorization and attestation	_____
Person Being Referred	_____
Full Name	_____
Date of Birth	____ / ____ / _____
Sex / Gender	_____
Phone Number	_____
Street Address	_____
City, State, ZIP Code	_____
County, NC	_____
Payer / Program Information	_____
Referral Source Type	☐ _____ ☐ Other: _____
Member / Participant ID	_____
Managed Care Plan or Program Name	_____
Funding Source	_____
Eligibility / Authorization Details	_____ _____
Requested Home Care Services	_____
Requested Service Types	☐ _____ ☐ Other: _____
Referral Type	☐ _____ ☐ Other: _____
Start-of-Care Timing	_____
Preferred Start Date	____ / ____ / _____
Requested Hours or Frequency	_____
Preferred Days of Week	_____
Service Preferences, Special Instructions, and Caregiver Support Needs	_____
Clinical & Safety Details	

	_____ _____
Primary diagnosis or reason for referral	_____ _____
Relevant diagnoses or medical conditions	_____
Mobility and transfer needs	_____
Activities of daily living support needed	_____
Cognitive or communication concerns	_____ _____
Behavioral or safety risks	_____ _____
Certification & Submission	_____
Certification and Attestation	_____
Submitter Name	_____
Title / Role	_____
Submit Secure Referral	_____
Administrative Details	_____ _____
Direct NPI	_____
Preferred contact method	☐ _____ ☐ Other: _____
Guardian or authorized representative name	_____
Guardian or authorized representative phone	_____
Guardian or authorized representative email	_____
Case Management Information	_____
Case-management entity	_____
Case manager name	_____
Case manager phone	_____
Case manager email	_____
Authorization Details	_____ _____
Authorization number	_____
Authorization status	☐ _____ ☐ Other: _____
Approved units or hours	_____
Authorization effective date	____ / ____ / _____
Authorization end date	____ / ____ / _____
Skilled Nursing Details	_____ _____
Signed order or prescriber	_____

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Requested nursing tasks	_____
Skilled nursing frequency	_____
Skilled nursing duration	_____
Clinical Details	_____ _____
Allergies	_____
Infection-control precautions	_____
Equipment	_____
Current location	_____
Anticipated discharge date	____ / ____ / _____
Supporting Documents	☐ Attached ☐ To follow ☐ Not applicable
Signed order	_____
Service authorization	_____
Person-centered service plan	_____
Plan of care	_____
Clinical notes supporting skilled services	_____ _____
Discharge summary	_____
Insurance card	_____
Other supporting documents	☐ Attached ☐ To follow ☐ Not applicable
Typed signature (full legal name)	Signature: _____

Office use only

Date received	
Intake staff	
Missing documentation follow-up	
Status / reference number	