

Vital Health Services - Patient Product Intake & Coverage Review

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.

Patient & Representative Information

Person Completing This Form	_____
Patient Legal Name	_____
Date of Birth	___ / ___ / ___
Sex as Listed with Insurer	_____
Service Address	_____
Mailing Address if Different	_____
Phone Number	_____
Email Address	_____
Preferred Contact Method	☐ _____ ☐ Other: _____
Caregiver / Representative Contact Name	_____

Insurance & Coverage Review

Primary Insurance Name	_____
Member ID	_____
Group Number	_____
Plan Phone	_____
Secondary Insurance Name	_____
Upload Insurance Card Front and Back	☐ Attached ☐ To follow ☐ Not applicable

Authorization and Coverage Review Permissions

Current Supplier	_____
Urgency	_____

Prescriber & Clinical Basics

Prescribing clinician name	_____
Practice name	_____
Practice phone	_____
Practice fax	_____
Primary diagnosis or condition	_____ _____
Height (inches)	_____
Weight (lbs)	_____

Urology Supplies

Catheter type needed/currently used	☐ _____ ☐ Other: _____
Catheter French size	_____
Catheter length	_____
Quantity per day	_____
Primary condition/indication	_____
Ability to self-catheterize	_____
Reason coude catheter is needed	_____
Sterile kit needed	_____
Current product/manufacturer	_____
Last shipment date	____ / ____ / ____
Skin sensitivity or latex allergy	_____
Upload prescription or clinical notes	☐ Attached ☐ To follow ☐ Not applicable

Incontinence Supplies

Supplies Requested	_____
Pediatric or Adult	_____
Incontinence Type	☐ _____ ☐ Other: _____
Mobility / Toileting Status	☐ _____ ☐ Other: _____
Underlying Diagnosis	_____ _____
Caregiver Assistance	_____
Skin Breakdown Present	_____
Current Brand	_____
Last Shipment	_____
Upload Prescription / Records (Optional)	☐ Attached ☐ To follow ☐ Not applicable

Supply Details

Nutrition Supplies

Nutrition delivery method	☐ _____ ☐ Other: _____
Product/formula currently prescribed	_____
Flavor	_____
Calories per container	_____
Containers per day	_____
Feeding route	☐ _____ ☐ Other: _____
Delivery method	☐ _____ ☐ Other: _____
Diagnosis causing impaired nutrition	_____ _____
Allergies or intolerances	_____

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Height (inches)	_____
Weight (lbs)	_____
Recent weight change	_____
Percentage of nutrition from formula	_____
Able to eat regular food	_____
Requested supplies	_____
Current product or NDC, if known	_____
Upload supporting documents	☐ Attached ☐ To follow ☐ Not applicable

General DME

Requested DME Items	_____
Request Type	☐ _____ ☐ Other: _____
Diagnosis and functional limitation	_____ _____
Where will the item be used?	☐ Yes ☐ No ☐ N/A Details: _____
Ability to move inside the home	_____
Difficulty with activities of daily living	_____
History of falls	_____ _____
Current equipment in use	_____
Age of current equipment	_____
Patient height	_____
Patient weight	_____
Home access limitations	_____ _____
Expected discharge date	___ / ___ / ____
Clinician recommendation	_____

Product specifics by selected item

Upload prescription or clinical notes	☐ Attached ☐ To follow ☐ Not applicable
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Consent, Checklist & Signature**Consent acknowledgements****Upload checklist****Acknowledgements and attestations**

Typed patient or representative name	☐ _____ ☐ Other: _____
Relationship to patient	_____
Signature	Signature: _____

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Date	___ / ___ / ___
Document upload	☐ Attached ☐ To follow ☐ Not applicable
Securely submit for review	_____
Preferred Language	_____
Product Category	☐ _____ ☐ Other: _____
Dietitian involved	_____
Swallow evaluation completed	_____
Last shipment date	___ / ___ / ___
Has regular food or a modified diet been tried?	☐ Yes ☐ No ☐ N/A Details: _____
Why is it insufficient?	☐ Yes ☐ No ☐ N/A Details: _____
Daytime size	_____
Nighttime size	_____
Waist/hip measurement	_____
Quantity per day	_____

Office use only

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