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

Vital Health Services - Medicare DMEPOS Standard Written Order & Medical Necessity

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.

Beneficiary Information

Beneficiary Legal Name	_____
Medicare Beneficiary Identifier (MBI)	_____
Date of Birth	____ / ____ / _____
Residential Address	_____
Phone Number	_____
Authorized Representative Name (if applicable)	_____
Height (inches)	_____
Weight (lb)	_____

Treating Practitioner Information

Treating Practitioner Name	_____
Credentials	_____
NPI	_____
Specialty	_____
Practice/Clinic Name	_____
Practice Address	_____
Practice Phone	_____
Fax Number	_____
Secure Email	_____
Office Contact Name and Phone	_____

Order Information

Order type	☐ _____ ☐ Other: _____
Product category	☐ _____ ☐ Other: _____

CMS Standard Written Order (SWO)

Beneficiary Name	_____
Medicare Beneficiary Identifier (MBI)	_____
Order Date	____ / ____ / _____
Item Description / Narrative	_____ _____

HCPCS Code	_____
Billed Options / Accessories / Supplies	_____
Quantity to Dispense	_____
Treating Practitioner Signature	Signature: _____

Medical Record Support

Diagnosis / Condition	_____ _____
ICD-10 Code (if known)	_____
Onset / Duration	_____
Current Symptoms	_____ _____
Severity	_____
Functional Limitations	_____ _____
ADLs / MRADLs Affected	_____
Home Use Requirements	_____
Clinical Course / Progression	_____ _____
Prognosis	_____ _____
Prior Interventions / Equipment Tried and Results	_____
Why Alternatives Are Insufficient	_____ _____
Expected Benefit and Why the Type, Quantity, and Frequency Are Reasonable and Necessary	_____ _____

Face-to-Face and Written Order Prior to Delivery Screening

Is the item on a current CMS required list or a power mobility device?	☐ Yes ☐ No ☐ N/A Details: _____
If yes, explain the CMS list / power mobility device basis	_____ _____
Date of qualifying face-to-face encounter	____ / ____ / _____
Method of face-to-face encounter	☐ _____ ☐ Other: _____
Practitioner who performed the encounter	_____
Does the encounter documentation support the ordered item?	☐ Attached ☐ To follow ☐ Not applicable
If no, explain the documentation gap	☐ Attached ☐ To follow ☐ Not applicable

Date completed SWO was communicated to supplier	____ / ____ / _____

Product-Specific Details: Urology

Catheter Type	☐ _____ ☐ Other: _____
French Size	_____
Length	_____
Straight or Coude	_____
Clinical Reason for Straight or Coude Selection	_____ _____
Frequency per Day	_____
Sterile Kits Required	_____
Diagnosis and Retention Details	_____ _____
Self-Catheterization	_____

Product-Specific Details: Enteral/Parenteral Nutrition

Nutrition Type	☐ _____ ☐ Other: _____
Formula or Nutrient Product	_____
Route of Administration	☐ _____ ☐ Other: _____
Calories per Day	_____
Containers per Day	_____
Feeding Schedule or Method	☐ _____ ☐ Other: _____
Pump Required	_____
Percentage of Nutrition Provided	_____
Permanence or Impairment Description	_____
Tube Details	_____ _____
Supplies Needed	_____

Product-Specific Details: Diabetes/CGM

Diabetes diagnosis	_____ _____
Insulin regimen	_____
Frequency of insulin administration	_____
Problematic hypoglycemia	_____
Problematic hypoglycemia details	_____ _____
Most recent relevant visit date	____ / ____ / _____
Diabetes training completed	_____

Current CGM system and requested receiver, sensors, transmitter, and quantities	_____

Product-Specific Details: Mobility

MRADLs affected	_____
Home use description	_____
Why cane or walker is insufficient	_____ _____
Ambulation description	_____
Falls history	_____ _____
Strength and range of motion	_____
Transfer ability	_____
Manual wheelchair ability	_____
Caregiver availability	_____
Power mobility evaluation details	_____ _____
Accessories requested	_____

Product-Specific Details: Hospital Bed/Support Surface

Why is positioning not feasible in an ordinary bed?	☐ Yes ☐ No ☐ N/A Details: _____
Needed head elevation level	_____
Why is frequent or immediate position change medically necessary?	☐ Yes ☐ No ☐ N/A Details: _____
Is traction required?	☐ Yes ☐ No ☐ N/A Details: _____
If traction is required, describe the clinical need and setup	_____ _____
Describe wounds or pressure injuries, including stage, location, and measurements	_____ _____
Describe mobility limitations relevant to hospital bed or support surface need	_____ _____
List prior support surfaces tried and the results	_____

Product-Specific Details: PAP/Respiratory

Diagnosis / Testing Date	____ / ____ / _____
Testing Type	☐ _____ ☐ Other: _____
Sleep Study or Oxygen Testing Details	_____ _____
Device and Settings	_____

Qualifying Results	_____
Symptoms and Prior Therapy	_____ _____
Accessories Requested	_____

Product-Specific Details: Orthotics/Bracing

Body location	_____
Laterality	_____
Diagnosis / condition	_____ _____
Instability / clinical findings	_____ _____
Device type	☐ _____ ☐ Other: _____
Expected duration of use	_____
Expected use / wearing schedule	_____

Product-Specific Details: Wound Supplies

Wound location / type	☐ _____ ☐ Other: _____
Wound stage / depth	_____
Wound measurements (length × width × depth)	_____
Drainage, treatment, and debridement details	_____ _____
Dressing type, change frequency, and quantity	☐ _____ ☐ Other: _____

Product-Specific Details: Other DMEPOS

Detailed Item Description	_____
Specifications and Configuration	_____ _____
Medical Need and Clinical Justification	_____ _____
Why Alternatives Are Insufficient	_____ _____

Documentation Uploads

Signed Order (if separately prepared)	_____
Contemporaneous Office Notes	_____ _____
Face-to-Face Note	_____

Testing Results	_____
Therapy or ATP Evaluation	_____
Discharge Records	_____
Sleep Study or Oxygen Test	_____
Wound Records and Other Policy-Specific Documentation	☐ Attached ☐ To follow ☐ Not applicable

Practitioner Certification and Signature

Practitioner Certification	_____
Typed Practitioner Name	☐ _____ ☐ Other: _____
Electronic Signature	Signature: _____
Date Signed	____ / ____ / _____
Submit Order	_____

Office use only

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