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 - NC Medicaid DME Order, Medical Necessity & Prior Approval

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 Information

Patient legal name	_____
Date of birth	____ / ____ / _____
NC Medicaid member ID	_____
Home address	_____
Phone number	_____
County of residence	_____
Managed-care plan	_____
Representative or contact name	_____
Height (inches)	_____
Weight (pounds)	_____

Ordering Practitioner Information

Practitioner Name	_____
Credentials	_____
National Provider Identifier (NPI)	_____
Taxonomy / Specialty	_____
Practice Name	_____
Practice Address	_____
Practice Phone	_____
Practice Fax	_____
Secure Email for Administrative Communication (not for ordinary PHI)	_____
Primary Contact Person	_____

Order Details

Request Type	☐ _____ ☐ Other: _____
Product Category	☐ _____ ☐ Other: _____
Item Description	_____
HCPCS Code	_____
Brand / Model	_____
Quantity	_____
Frequency	_____
Route / Method	☐ _____ ☐ Other: _____

Length of Need	_____
Start Date	____ / ____ / _____

Medical Necessity Narrative

Diagnosis and onset details	_____ _____
Symptoms and functional limitations	_____ _____
Activities of daily living affected	_____
Why the item is needed in the home	_____ _____
Prior treatments or equipment tried and outcome	_____ _____
Why a less costly alternative is not sufficient	_____ _____
Expected clinical benefit	_____ _____
Expected prognosis	_____ _____
Risks without the item	_____ _____

Prior Approval / CMN Information

Requested Date	____ / ____ / _____
Urgency of Request	_____
Urgency Explanation	_____
EPSDT Screening Required for Member Under 21?	☐ Yes ☐ No ☐ N/A Details: _____
Other Insurance or Medicare Coverage?	☐ Yes ☐ No ☐ N/A Details: _____
Current Supplier	_____
Last Delivery Date	____ / ____ / _____
Replacement Reason and Age of Current Equipment	_____
Discharge Date, if Applicable	____ / ____ / _____

Urology

Catheter Type	☐ _____ ☐ Other: _____
French Size (Fr)	_____
Catheter Length	_____
Reason for Straight or Coude Selection	_____

Sterile Kit Required	_____
Frequency Per Day	_____
Primary Indication	_____
Ability to Self-Catheterize	_____
Latex Sensitivity	_____

Incontinence

Patient Group	_____
Diagnosis Causing Incontinence	_____ _____
Type of Incontinence	☐ _____ ☐ Other: _____
Mobility Status	☐ _____ ☐ Other: _____
Toileting Status	☐ _____ ☐ Other: _____
Supplies Needed	_____
Garment Size	_____
Waist / Hip Measurements	_____
Absorbency Level	_____
Daytime Quantity Needed per Day	_____
Nighttime Quantity Needed per Night	_____
Skin Breakdown Present	_____
Caregiver Assistance Needed	_____

Enteral / Oral Nutrition

Route of Nutrition	☐ _____ ☐ Other: _____
Formula / Product	_____
Calories per Container	_____
Containers per Day	_____
Calories per Day	_____
Feeding Method	☐ _____ ☐ Other: _____
Feeding Schedule	_____
Percentage of Nutrition from Formula	_____
Growth / Weight History	_____ _____
Swallowing / Feeding Evaluation Completed	_____
Failed Regular or Modified Diet / Other Interventions	_____
Allergies / Intolerance	_____
Dietitian Involved	_____
Tube Type / Size and Supplies	☐ _____ ☐ Other: _____

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Diabetes / CGM

Diabetes type	☐ _____ ☐ Other: _____
Insulin use	_____
Insulin regimen	_____
Treatment frequency	_____ _____
Problematic hypoglycemia	_____
Current device	_____
Receiver needed	_____
Prescriber visit date	____ / ____ / _____
Requested system and quantities	_____

Mobility

Mobility product type	☐ _____ ☐ Other: _____
Which MRADLs are impaired?	☐ Yes ☐ No ☐ N/A Details: _____
Where will the mobility device be used?	☐ Yes ☐ No ☐ N/A Details: _____
Typical ambulation distance without assistance (feet)	_____
History of falls in the past 12 months	_____ _____
Upper and lower extremity function	_____
Transfer ability	_____
Caregiver available to assist with mobility needs	_____
Home accessibility concerns	_____ _____
Seating / accessory needs	_____

Hospital Bed / Support Surface

Positioning need	_____
Related clinical needs	_____ _____
Head elevation required	_____
Frequent position changes needed	_____
Wounds	_____
Mobility status	☐ _____ ☐ Other: _____
Prior support surfaces used	_____
Additional clinical justification	_____ _____

Bathroom / Safety Equipment

Requested Item	☐ _____ ☐ Other: _____
Transfer Assistance Needed	_____
History of Falls in Bathroom	_____ _____
Bathroom Accessibility	_____
Functional Limitation Supporting Need	_____

Orthotics / Bracing

Body Location	_____
Laterality	_____
Diagnosis / Injury	_____ _____
Instability Description	_____
Examination Findings	_____
Orthosis Type	☐ _____ ☐ Other: _____
Expected Duration (months)	_____

Wound Supplies

Wound Location	_____
Wound Type / Stage	☐ _____ ☐ Other: _____
Wound Dimensions	_____
Drainage	_____
Debridement Needed	_____
Treatment Plan	_____ _____
Dressing Type / Frequency / Quantity	☐ _____ ☐ Other: _____

Other DME

Other DME Item	_____
Functional Need	_____
Conservative Alternatives Tried	_____
Item Specifications / Measurements	_____ _____

Secure Uploads

Signed Prescription / Order	_____
Recent Clinical Notes	_____ _____
Hospital Discharge Documents	☐ Attached ☐ To follow ☐ Not applicable

Therapy Evaluation	_____
Nutrition Assessment	_____
Wound Measurements / Photos	_____
Insurance Cards	_____
Other Supporting Records	_____

Practitioner Certification and Electronic Signature

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

Office use only

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