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 Medical Supply - CGM Provider Referral & Standard Written Order

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 office and submitter	_____
Practice / Facility Legal Name	_____
Practice Address	_____
Main Phone	_____
Secure Fax	_____
Submitter Full Name	_____
Role / Title	_____
Direct Phone	_____
Secure Email	_____
Submitter Relationship to Ordering Practitioner	_____
Preferred Follow-up Method for Missing Documents	☐ Attached ☐ To follow ☐ Not applicable
Referral Date	____ / ____ / _____
Patient demographics	_____
Patient legal name	_____
Date of birth	____ / ____ / _____
Phone	_____
Service/shipping address	_____
Preferred language	_____
Medicare Beneficiary Identifier or insurance member ID	_____
Primary payer	_____
Primary plan name	_____
Primary member ID	_____
Primary group number	_____
Upload front of primary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Upload back of primary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Secondary payer	_____
Secondary plan name	_____
Secondary member ID	_____
Secondary group number	_____
Upload front of secondary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Upload back of secondary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Diagnoses and clinical screening	

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	_____ _____
Diabetes diagnosis	_____ _____
ICD-10-CM code(s)	_____
Date of diabetes diagnosis	____ / ____ / _____
Current diabetes treatment	_____ _____
Insulin name(s)	_____
Insulin prescribed frequency or regimen	_____
Insulin-treated	_____
Documented history of problematic hypoglycemia	☐ Attached ☐ To follow ☐ Not applicable
If yes, qualifying hypoglycemia history	_____ _____
Date(s) and details of hypoglycemia events	____ / ____ / _____
Supporting documentation for hypoglycemia history	☐ Attached ☐ To follow ☐ Not applicable
Date of most recent in-person or telehealth diabetes follow-up	____ / ____ / _____
Clinical rationale / medical necessity	_____ _____
CGM evaluation, training, and follow-up attestations	_____
CGM standard written order	_____
Order date	____ / ____ / _____
Requested CGM system	_____
Receiver needed?	☐ Yes ☐ No ☐ N/A Details: _____
Sensors	_____
Transmitter (if applicable)	_____
Other related diabetes supplies	_____
Length of need	_____
Substitution / equivalent product instruction	_____
Allergies or skin / adhesive concerns	_____ _____
Special delivery or accessibility instructions	_____
Disclaimer	_____
Supporting records upload	☐ Attached ☐ To follow ☐ Not applicable
Do not email PHI separately; upload through this secure form or use Vital Health's secure fax.	☐ Attached ☐ To follow ☐ Not applicable
Signed prescription or order	_____

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Most recent diabetes office note	_____
Medication or insulin list	_____
Blood glucose or hypoglycemia documentation (if applicable)	☐ Attached ☐ To follow ☐ Not applicable
Prior authorization or payer-specific form (if available)	_____
Other supporting documents	☐ Attached ☐ To follow ☐ Not applicable
Ordering practitioner	_____
Practitioner full legal name	_____
Credentials	_____
Individual NPI	_____
Specialty / taxonomy	_____
Practice address	_____
Practice phone	_____
Fax number	_____
PECOS enrollment confirmed if Medicare applies	_____
State license number	_____
State of license	_____
Practitioner electronic signature	Signature: _____
Final office checklist	_____
Checklist confirmations	_____
Are the patient demographics verified?	☐ Yes ☐ No ☐ N/A Details: _____
Are insurance cards attached?	☐ Attached ☐ To follow ☐ Not applicable
Is a recent clinical note attached?	☐ Attached ☐ To follow ☐ Not applicable
Is the signed order completed or attached?	☐ Attached ☐ To follow ☐ Not applicable
Is insulin regimen or hypoglycemia documentation included when applicable?	☐ Attached ☐ To follow ☐ Not applicable
Submit Secure Referral	_____
Current CGM supplier	_____
Date of last CGM shipment	____ / ____ / _____
Overlap warning acknowledgment	_____
Sensor item/brand description	_____
Sensor quantity to dispense	_____
Sensor replacement/refill frequency	_____
Sensor number of refills	_____
Transmitter item/brand description	_____
Transmitter quantity to dispense	_____
Transmitter replacement/refill frequency	_____
Transmitter number of refills	_____
Office contact for missing documentation	☐ Attached ☐ To follow ☐ Not applicable

Office direct phone	_____
Office secure email	_____
Practitioner signature date	Signature: _____
Is the patient currently receiving CGM supplies from another supplier?	☐ Yes ☐ No ☐ N/A Details: _____
Who is signing/submitting this form?	☐ Yes ☐ No ☐ N/A Details: _____
Practitioner attestation	_____
Referral/intake only - not a valid signed order unless separately signed by the practitioner.	_____
Documented problematic hypoglycemia?	☐ Attached ☐ To follow ☐ Not applicable
Does the patient have secondary insurance?	☐ Yes ☐ No ☐ N/A Details: _____

Office use only

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