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 - Provider Referral & DME 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.

Patient & Referral Details	_____ _____
Referral Type	☐ _____ ☐ Other: _____
Product Category	☐ _____ ☐ Other: _____
Patient Legal Name	_____
Date of Birth	____ / ____ / _____
Sex as Listed with Insurer	_____
Patient Address	_____
Patient Phone	_____
Representative / Caregiver Name	_____
Primary Insurance Member ID	_____
Secondary Insurance Member ID	_____
Primary Insurance Provider	_____
Secondary Insurance Provider	_____
Upload Insurance Cards	☐ Attached ☐ To follow ☐ Not applicable
Ordering Practitioner & Facility Information	_____
Ordering practitioner full name	_____
Credentials	_____
Individual NPI	_____
Taxonomy / specialty	_____
Practice / facility name	_____
Practice / facility address	_____
Office phone and fax	_____
Secure email	_____
Contact person	_____
Clinical Basis for Order	_____ _____
Date of face-to-face or qualifying evaluation	____ / ____ / _____
Diagnosis code(s) and descriptions	_____ _____
Prognosis / duration of need	_____ _____
Clinical narrative / functional limitation	_____

	_____
Chart note upload	☐ Attached ☐ To follow ☐ Not applicable
Signed prescription / order upload	☐ Attached ☐ To follow ☐ Not applicable
Urology Supplies (Conditional)	_____
Supply Type	☐ _____ ☐ Other: _____
HCPCS Code	_____
Manufacturer / Model	_____
French Size	_____
Length	_____
Tip Type	☐ _____ ☐ Other: _____
Lubrication / Kit Features	_____
Quantity Per Day	_____
Quantity Per Month	_____
Refills	_____
Length of Need	_____
Diagnosis	_____ _____
Can the patient self-catheterize?	☐ Yes ☐ No ☐ N/A Details: _____

Medical Necessity Narrative

Urology Item Details	_____ _____
Incontinence Supplies (Conditional)	_____
Incontinence product types	☐ _____ ☐ Other: _____
Patient group	_____
Size	_____
Measurements or fit details	_____ _____
Units per day	_____
Units per month	_____
Primary incontinence type	☐ _____ ☐ Other: _____
Underlying diagnosis causing incontinence	_____ _____
Mobility and toileting ability	_____
Caregiver assistance needed	_____
Medical-necessity narrative	_____ _____
Nutrition Supplies (Conditional)	_____
Nutrition supply type	☐ _____ ☐ Other: _____
Formula or product name	_____

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HCPCS code	_____
Product number	_____
Route	☐ _____ ☐ Other: _____
Calories per unit	_____
Units per day	_____
Units per month	_____
Total daily calories	_____
Percent of nutrition supplied	_____
Administration method	☐ _____ ☐ Other: _____
Pump and supply needs	_____
Diagnosis	_____ _____
Reason patient cannot maintain nutrition with ordinary food or modified diet	_____
Height	_____
Weight	_____
Weight history	_____ _____
BMI	_____
Relevant labs or assessment findings	_____
Swallowing or gastrointestinal impairment details	_____ _____
Dietitian assessment	_____
Length of need	_____
Refills	_____
Substitutions allowed	_____
Allergies or intolerances	_____
Upload LMN	☐ Attached ☐ To follow ☐ Not applicable
Upload nutrition evaluation	☐ Attached ☐ To follow ☐ Not applicable
Upload growth chart	☐ Attached ☐ To follow ☐ Not applicable
Upload swallow study	☐ Attached ☐ To follow ☐ Not applicable
Upload operative report	☐ Attached ☐ To follow ☐ Not applicable
Upload clinical notes	☐ Attached ☐ To follow ☐ Not applicable
General DME (Conditional)	_____
Requested item(s)	☐ _____ ☐ Other: _____
HCPCS code	_____
Detailed item description and accessories	_____
Quantity	_____
Frequency of use	_____
Length of need	_____
Order type	☐ _____ ☐ Other: _____

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Diagnosis and functional limitation	_____ _____
Activities of daily living affected	_____
Why lesser equipment is insufficient	_____ _____
Will the item be used in the home?	☐ Yes ☐ No ☐ N/A Details: _____
Height	_____
Weight	_____
Current equipment and reason for replacement	_____
Face-to-face evaluation date	____ / ____ / _____
Medical-necessity narrative	_____ _____
Supporting Documents & Certification	☐ Attached ☐ To follow ☐ Not applicable
Supporting documents included	☐ Attached ☐ To follow ☐ Not applicable
Provider attestation and certification	_____
Provider typed name	☐ _____ ☐ Other: _____
Credentials	_____
Individual NPI	_____
Electronic signature	Signature: _____
Signed date	____ / ____ / _____
Preferred secure follow-up method	☐ _____ ☐ Other: _____
Submit Secure Referral	_____

Office use only

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