VITAL DOCTORS
MEDICAL EQUIPMENT
Compassionate Care. Quality Equipment. Better Lives.

(833) 432-4247
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9523 I-35 Frontage Rd., Suite #2
San Antonio, TX 78233

STAFF USE ONLY

MEDICAL RECORDS RECEIPT & REVIEW CHECKLIST

(STAFF USE ONLY)

PATIENT / REQUEST INFORMATION

Patient Name: _____ DOB: _____ Member ID: _____

Ordering / Referring Provider: _____ Date Records Requested: _____

Request Sent To (Provider / Facility): _____ Date Records Received: _____

Requested By (Staff): _____ Method Received: ☐ Fax ☐ Secure Email ☐ Portal ☐ Mail ☐ Other: _____

REQUIRED DOCUMENTATION CHECKLIST

DOCUMENT / RECORD	RECEIVED (Y)	COMPLETE (Y)	N/A	NOTES / COMMENTS
☐ Face-to-Face Encounter Notes	☐	☐	☐	_____
☐ Most Recent Physician Chart Notes	☐	☐	☐	_____
☐ History & Physical (H&P)	☐	☐	☐	_____
☐ Office Visit Notes	☐	☐	☐	_____
☐ Progress Notes	☐	☐	☐	_____
☐ Diagnosis (ICD-10)	☐	☐	☐	_____
☐ Medication List	☐	☐	☐	_____
☐ Standard Written Order (SWO)	☐	☐	☐	_____
☐ Prescription	☐	☐	☐	_____
☐ Medical Necessity / Clinical Justification	☐	☐	☐	_____
☐ Relevant Testing / Diagnostic Reports (e.g., X-ray, MRI, Sleep Study, PFT, etc.)	☐	☐	☐	_____
☐ Physical Therapy Notes	☐	☐	☐	_____
☐ Occupational Therapy Notes	☐	☐	☐	_____
☐ Wound Care Documentation	☐	☐	☐	_____
☐ Hospital Discharge Summary	☐	☐	☐	_____
☐ Other Operative Reports	☐	☐	☐	_____
☐ Laboratory Results	☐	☐	☐	_____
☐ Prior Authorization (if applicable)	☐	☐	☐	_____
☐ Demographics / Insurance Information	☐	☐	☐	_____
☐ Additional Notes / Other _____	☐	☐	☐	_____

REVIEW SUMMARY

☐ Complete – Ready to Submit
☐ Incomplete – Additional Information Needed
☐ Not Sufficient for Medical Necessity
☐ Returned to Provider
☐ Other: _____

Comments / Missing Information Needed:

_____
_____
_____
_____

FOLLOW-UP ACTIONS

☐ Additional records requested on: _____
☐ Follow-up call made on: _____
☐ Additional records received on: _____
☐ Escalated to Supervisor on: _____
☐ Returned to provider for missing information
☐ Other: _____

Notes:

_____
_____
_____
_____

DOCUMENTATION REVIEWED FOR

☐ Medical Necessity ☐ Insurance Requirements ☐ Prior Authorization ☐ Billing / Claim Submission ☐ Audit / Compliance
☐ Other: _____

STAFF REVIEW / APPROVAL

Reviewed By (Print): _____ Title / Department: _____

Signature: _____ Date: _____

CONFIDENTIAL – FOR INTERNAL USE ONLY

This information is confidential and intended solely for use by Vital Doctors Medical Equipment staff. Maintaining accurate and complete documentation ensures compliance with Medicare, Medicaid, and commercial insurance requirements.

Form VDM-MR-002
Rev. 05/14/2025

Our goal is accurate documentation and timely care for every patient. Questions? Contact us at **(833) 432-4247**.