



VITAL DOCTORS

MEDICAL EQUIPMENT

MEDICAL RECORDS / PHYSICIAN DOCUMENTATION REQUEST

Office: (833) 432-4247 **Fax:** (833) 542-2009
Address: 9523 N Interstate 35, Ste 2, San Antonio, TX 78233

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ Phone: _____
Address: _____
Insurance/Payer: _____ Member ID: _____

REQUEST TO PHYSICIAN / HEALTHCARE PROVIDER

Provider/Practice Name: _____
Physician/Practitioner: _____
Phone: _____ Fax: _____

Vital Doctors Medical Equipment is assisting the above patient with durable medical equipment. Please provide the applicable medical records and supporting documentation needed to evaluate medical necessity, process the equipment order, and support payer documentation requirements.

DOCUMENTATION REQUESTED

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| ☐ Recent office / progress notes | ☐ Face-to-face encounter documentation |
| ☐ DME prescription / Standard Written Order | ☐ Diagnosis and condition(s) supporting medical necessity |
| ☐ History and physical | ☐ Hospital / discharge records |
| ☐ Therapy evaluation (PT / OT), if applicable | ☐ Prior authorization documentation, if applicable |
| ☐ PCP referral, if applicable | ☐ Other: _____ |

EQUIPMENT / ORDER INFORMATION

Requested Equipment: _____
HCPCS Code(s), if known: _____
Ordering Provider: _____
Date of Order / Requested Service Date: _____

RETURN RECORDS

Please return the requested documentation by secure fax to **(833) 542-2009**. If you have questions regarding this request, please call **(833) 432-4247**.

Privacy Notice: The information requested should be limited to documentation reasonably necessary for the patient's DME order, payment, and related healthcare operations. Please transmit protected health information using an appropriate secure method.

Requested By: _____ Date: _____

Title/Department: _____ Follow-up Date: _____