

Vital Health Medical Supply - CGM Eligibility & Supply Request

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.

Who is Completing This	_____
Who is completing this form?	☐ Yes ☐ No ☐ N/A Details: _____
Submitter full name	_____
Relationship to patient	_____
Submitter phone number	_____
Submitter email address	_____

Patient Information

Legal First Name	_____
Legal Last Name	_____
Date of Birth	____ / ____ / ____
Preferred Phone	_____
Email Address	_____
Service / Shipping Address	_____
Preferred Contact Method	☐ _____ ☐ Other: _____
Preferred Language	_____
North Carolina Resident	_____
Insurance	_____
Primary insurance type	☐ _____ ☐ Other: _____
Payer/plan name	_____
Member ID	_____
Group number	_____
Upload front of primary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Upload back of primary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Does the patient have secondary insurance?	☐ Yes ☐ No ☐ N/A Details: _____
Secondary payer/plan name	_____
Upload front of secondary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Upload back of secondary insurance card	☐ Attached ☐ To follow ☐ Not applicable
Diabetes and CGM Screening	_____
Has a healthcare practitioner diagnosed diabetes?	☐ Yes ☐ No ☐ N/A Details: _____
Diabetes type	☐ _____ ☐ Other: _____
Current diabetes treatment	_____ _____
If using insulin injections, how many times	☐ Yes ☐ No ☐ N/A Details: _____

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per day?	
If using insulin, list insulin name(s)	_____
If using insulin, are you unsure of the insulin name(s)?	☐ Yes ☐ No ☐ N/A Details: _____
Has the patient experienced documented problematic hypoglycemia?	☐ Attached ☐ To follow ☐ Not applicable
Current CGM use	_____
Requested or preferred CGM system	_____
Does the patient have a compatible smartphone?	☐ Yes ☐ No ☐ N/A Details: _____
May a dedicated receiver be needed?	☐ Yes ☐ No ☐ N/A Details: _____
Date of most recent diabetes visit	____ / ____ / ____
Treating practitioner full name	_____
Treating practitioner practice name	_____
Treating practitioner phone	_____
Treating practitioner fax (if known)	_____
Practice city	_____
Practice state	_____
Permission for Vital Health to contact the practitioner and insurer for prescription, documentation, benefit verification, authorization, treatment, payment, and healthcare operations	☐ Attached ☐ To follow ☐ Not applicable
Current Supplier and Timing	_____
Is the patient currently receiving CGM supplies from another supplier?	☐ Yes ☐ No ☐ N/A Details: _____
Current supplier name	_____
Date of last shipment, if known	____ / ____ / ____
Reason for requested change	_____
When are supplies needed?	☐ Yes ☐ No ☐ N/A Details: _____
Additional comments	_____
Acknowledgments and Electronic Signature	Signature: _____
Acknowledgment statements	_____
Consent to be contacted by phone calls	_____
Consent to be contacted by secure email	_____
Consent to receive text messages	_____
Signature	Signature: _____
Printed name	_____
Relationship to patient	_____
Date	____ / ____ / ____
Submit Secure Request	_____

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Authorized to act for the patient	_____
Policyholder full name	_____
Policyholder date of birth	____ / ____ / ____
Policyholder relationship to patient	_____
Secondary member ID	_____
Secondary group number	_____
Overlapping-supplier warning	_____
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Is the patient the primary insurance policyholder?	☐ Yes ☐ No ☐ N/A Details: _____

Office use only

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