Durable Medical Equipment (DME), Home Health & Home Infusion Referral Form

Standard Request Fax to 1-866-534-5978
Hospital Discharges Fax to 1-844-801-8413
LTC DME/HH Fax to 1-855-266-5275

sunshine health™

P.O. Box 459089
Fort Lauderdale, FL 33345-9089

1-844-477-8313
Monday through Friday 8 a.m.–5 p.m.

Please fax this completed form along with associated clinical information or medical records to Sunshine Health. Lack of clinical information may result in delayed determination. *Indicates Required Field

Member Information

*Member First Name:	*Member Last Name:
*Member ID #:	*Member Date of Birth:
*Member Home Address:	*Service Address (if different from home): Alternative Contact Person: _____ Relationship to Member: _____
*Member Phone Number:	Alternative Contact Phone Number: _____
Member Height (in inches):	Member Weight (in pounds):

Requesting Provider Information

◯New Request ◯Extension Request	Date member last seen by requesting provider:
Requesting Provider NPI:	Requesting Provider TIN:
*Requesting Provider Name:	Requesting Provider Contact Name:
*Phone Number:	*Fax Number:

Servicing Provider Information

◯New Request ◯Extension Request	Date member last seen by servicing provider:
Servicing Provider NPI:	Servicing Provider TIN:
*Servicing Provider Name:	Servicing Provider Contact Name:
*Phone Number:	*Fax Number:

Information on services that require a prior authorization can be found at SunshineHealth.com. For questions please call Sunshine Health's Utilization Management Department at 1-844-477-8313 and select the prompt for home care or DME. We are open from 8 a.m. to 5 p.m. Monday through Friday.

Children's Medical Services Health Plan
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Authorization Request

☐ Check here if this request is related to an inpatient discharge.	*If a Discharge, Date of Discharge: Facility Name:
*Primary Diagnosis Code:	*Start Date of Service:
Additional Diagnosis Code:	End Date of Service:
Number of Total Units/Visits/Days Requested:	

***Member First Name:**	***Member Last Name:**
***Member ID Number:**	***Member Date of Birth:**

*Requested Services

Home Health		Oxygen/Respiratory Equipment
☐ Skilled Nurse	☐ Wound Care	Liter Flow Per Minute:
☐ LPN	☐ IV Infusion	Route: ☐ Nasal Cannula ☐ Simple Mask ☐ Other:
☐ Social Worker	Drug Name: _____ Drug Dosage: _____	Hours of Use: ☐ Continuous ☐ With Exertion ☐ Hours of Sleep ☐ Bleed into CPAP/BiPAP ☐ Other
☐ Home Health Aide	Frequency: _____ Duration of Treatment: _____	Delivery Device: ☐ Concentrator ☐ Portable Cylinders ☐ Conserving Device ☐ Liquid Helios Portable ☐ Other:
☐ Care Aide	Route of Administration:	Date of Saturation Test:
☐ Occupational Therapy		Oxygen Saturation of PO2 Results:
☐ Physical Therapy		☐ Apnea Monitor
☐ Respiratory Therapy		☐ BiPAP
☐ Speech Therapy		☐ CPAP
		☐ Nebulizer
		☐ Vent

Durable Medical Equipment

*HCPC Code:	Description:	Special Consideration:	Length of Need:

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Additional information:

Physician Attestation and Signature

I certify that I am the treating physician identified in this form and that I have ordered the noted services.

Physician Signature: _____ Date: _____

Physician's Printed Name: _____

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