Long Term Care Skilled Services Form

Fax to 1-855-266-5275

sunshine health™

1301 International Parkway
Suite 400
Sunrise, FL 33323

1-877-211-1999
Monday through Friday 8am – 5pm

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):
*Member Phone Number:	Alternative Contact Person: Relationship to Member: 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:

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:	

Information on services that require a prior authorization can be found at www.SunshineHealth.com. For questions please call Sunshine Health's Utilization Management Department at 1-877-211-1999 and select the prompt for home care or DME. We are open from 8 a.m. to 5 p.m. Monday through Friday.

Last Updated 3/23/2017

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

*Requested Services

Home Health	Oxygen/Respiratory Equipment
❍ Skilled Nurse	Liter Flow Per Minute:
❍ LPN	Route: ❍ Nasal Cannula
❍ Occupational Therapy	❍ Simple Mask ❍ Other:
❍ Physical Therapy	Hours of Use: ❍ Continuous
❍ Respiratory Therapy	❍ With Exertion ❍ Hours of Sleep
❍ Speech Therapy	❍ Bleed into CPAP/BiPAP
❍ Wound Care	❍ Other
	Delivery Device:
	❍ Concentrator ❍ Portable Cylinders
	❍ Conserving Device ❍ Liquid Helios Portable
	❍ Other:
	Date of Saturation Test:
	Oxygen Saturation of PO2 Results:
	❍ Apnea Monitor
	❍ BiPAP
	❍ CPAP
	❍ Nebulizer
	❍ Vent

Durable Medical Equipment

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

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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