CONNECTIONS REFERRAL FORM

Use this Form to refer a member to *Sunshine Health* for a visit from a CONNECTIONS Representative.

Date: _____ To: _____ From: _____

Member Name: _____

Medicaid ID #: _____ Member Phone #: _____

Member Address 1: _____
Address Apt. #

Member Address 2: _____
City State Zip Code

Provider Name: _____ Fax #: _____

Please check the reason for the Referral:

- ☐ Non-Compliance
- ☐ Missed Appointments (minimum of 3) - With appropriate documentation
- ☐ High Emergency Room usage
- ☐ Other (*please explain)* _____

Please give details as to the reason for the referral and your expectation of the CONNECTIONS visit:

_____

_____

_____

_____

HEALTHPLAN USE:

Date resolved: _____ Send to: _____

Reached Member ☐ Unable to Reach Member ☐

How many attempts made? ☐

Notes to Nurses (outline any special situations / instructions etc...)

Please fax completed form to your
Sunshine Health CONNECTIONS Representative
Fax #: 1(877)689-1056