



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

**Standard Request Fax to 866-534-5978**  
**Hospital Discharges Fax to 844-801-8413**



1301 International Parkway  
 Suite 400  
 Sunrise, FL 33323

**1-866-796-0530**  
 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

<input type="radio"/> New Request <input type="radio"/> 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

<input type="radio"/> 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](http://www.SunshineHealth.com). For questions please call Sunshine Health's Utilization Management Department at (866) 796-0530 and select the prompt for home care or DME. We are open from 8 a.m. to 5 p.m. Monday through Friday.

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

<b>*Member First Name:</b>	<b>*Member Last Name:</b>
<b>*Member ID Number:</b>	<b>*Member Date of Birth:</b>

*Requested Services		
Home Health		Oxygen/Respiratory Equipment

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

Durable Medical Equipment			
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*HCPC Code:	Description:	Special Consideration:	Length of Need:

Additional information:
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### 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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