



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

<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. 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.

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

*Requested Services	
Home Health	Oxygen/Respiratory Equipment
<input type="radio"/> Skilled Nurse	Liter Flow Per Minute:
<input type="radio"/> LPN	Route: <input type="radio"/> Nasal Cannula
<input type="radio"/> Occupational Therapy	<input type="radio"/> Simple Mask <input type="radio"/> Other:
<input type="radio"/> Physical Therapy	Hours of Use: <input type="radio"/> Continuous
<input type="radio"/> Respiratory Therapy	<input type="radio"/> With Exertion <input type="radio"/> Hours of Sleep
<input type="radio"/> Speech Therapy	<input type="radio"/> Bleed into CPAP/BiPAP
<input type="radio"/> Wound Care	<input type="radio"/> Other
	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:
	Date of Saturation Test:
	Oxygen Saturation of PO2 Results:
	<input type="radio"/> Apnea Monitor
	<input type="radio"/> BiPAP
	<input type="radio"/> CPAP
	<input type="radio"/> Nebulizer
	<input type="radio"/> 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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