Long Term Care Skilled Services Form

Fax to 1-855-266-5275

sunshine health™

1301 International Parkway
Suite 400
Sunrise, FL 33323

1-844-477-8313
Monday through Friday 8 a.m. – 8 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):
*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 SunshineHealth.com. For questions please call Sunshine Health's **Provider Services** at **1-844-477-8313**. We are open from 8 a.m. to 8 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
☐ 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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