CONNECTIONS REFERRAL FORM

Use this Form to refer a member to Sunshine State *Health Plan* 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:

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____

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...)

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Please fax completed form to your
Sunshine State Health Plan CONNECTIONS Representative
Fax #: 1(866)796-0527