5431 Beaumont Center Blvd.
Tampa, FL 33634

Telephone: (855)-444-3747
Fax: (855)-245-7418

FACSIMILE COVER SHEET

To:	eQHealth PDN/PPEC/CCM-SNF
Company:	
Phone:	
FAX	
From:	
Company:	eQHealth Solutions
Date:	
Pages incl. coversheet:	

Please only include one participant per fax cover sheet

Recipient Medicaid Number: _____

NEW REQUEST ___ EXISTING PARTICIPANT ___ SNF PARTICIPANT ____

Please attach the following documents as appropriate:
□ Demographic Sheet
□ Nursing Assessment
□ Most recent History and Physical (PDN only), or
□ Physician Monitoring Form (PDN only)
□ Ordering Provider Order (AHCA form or script including all the AHCA requirements)
□ Plan of Care
□ Referral contact information (Please print clearly)
□ Name: _____
□ Source: (family, ordering provider, PDN provider, PPEC provider/ Hospital Discharge planner)_____
□ Phone:_____
□ Email:_____

CONFIDENTIALITY OF INFORMATION