



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: _____

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