Contract Request Form

This form and the information you provide is used by Sunshine Health to evaluate the offering of a contract and is not representative of an application or Legal Agreement.

Provider Information

Legal Name (as it appears on W-9): _____

Dba Name (as it appears on License): _____

Tax ID:_____ NPI:_____ Medicaid ID:_____ Medicare ID:_____

Facility/Provider Type: _____ License #:_____

Contact Name: _____ Title: _____

Website Url: _____ Email: _____

Primary Address: _____ City/ST/Zip: _____

Region: ____ County: _____ Phone: _____ Fax: _____

Cell: _____ Hours/Bed Count: _____ Language(s): _____

Billing Address: _____

Servicing Counties	
☐**Region 1**	☐Escambia ☐Okaloosa ☐Santa Rosa ☐Walton
☐**Region 2**	☐Bay ☐Calhoun ☐Franklin ☐Gadsden ☐Gulf ☐Holmes ☐Jackson ☐Jefferson ☐Leon ☐Liberty ☐Madison ☐Taylor ☐Wakulla ☐Washington
☐**Region 3**	☐Alachua ☐Bradford ☐Citrus ☐Columbia ☐Dixie ☐Gilchrist ☐Hamilton ☐Hernando ☐Lafayette ☐Lake ☐Levy ☐Marion ☐Putnam ☐Sumter ☐Suwannee ☐Union
☐**Region 4**	☐Baker ☐Clay ☐Duval ☐Flagler ☐Nassau ☐St. Johns ☐Volusia
☐**Region 5**	☐Pasco ☐Pinellas
☐**Region 6**	☐Hardee ☐Highlands ☐Hillsborough ☐Manatee ☐Polk
☐**Region 7**	☐Brevard ☐Orange ☐Osceola ☐Seminole
☐**Region 8**	☐Charlotte ☐Collier ☐Desoto ☐Glades ☐Hendry ☐Lee ☐Sarasota
☐**Region 9**	☐Indian River ☐Martin ☐Okeechobee ☐Palm Beach ☐St. Lucie
☐**Region 10**	☐Broward
☐**Region 11**	☐Miami-Dade ☐Monroe
☐**Statewide**	

sunshine health

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SERVICE(S) ATTESTATION FORM

Services		
What population do you provide services for? ☐Adult ☐Pediatric Ages _____		
Please list any exclusions or limitations: _____		
☐Adult Companion	☐Home Accessibility Adaptation	☐Nutritional Assess & Risk Reduction
☐Adult Day Care	☐Home Delivered Meals	☐Personal Care
☐Assisted Living Facility Services	☐Homemaker	☐Personal Emergency Response Sys
☐Assistive Care Services	☐Hospice	☐Pest Control
☐Behavior Management	☐Medication Administration	☐Respite Care – In ALF
☐Caregiver Training	☐Medication Management	☐Respite Care – In Home
☐Durable Medical Equipment	☐Nursing Facility Care (SNF)	☐Transportation *(must be licensed)*
☐Private Duty Nursing - LPN *(**0-21 yrs**: 2 – 24 hours per day)*	☐Private Duty Nursing - RN *(**0-21 yrs**: 2 – 24 hours per day)*	☐Attendant Nursing Care *(**LTC only**: 2 – 24 hours per day)*
☐Intermittent Nursing- LPN *(1 – 2 hour visits per day)*	☐Intermittent Nursing- RN *(1 – 2 hour visits per day)*	☐Respiratory Therapy
☐Occupational Therapy	☐Physical Therapy	☐Speech Therapy
☐Medical Social Worker		

Please note: This is not a guarantee of a Contract. The information you provide is used by Sunshine Health to evaluate the offering of a Contract and is not representative of an application or Legal Agreement. Thank you!

_____

(Facility / Provider Name)

_____ _____

(Signature) *(Date)*

_____ _____

(Print Name) *(Position/Title)*

ambetter from Sunshine Health wellcare Children's Medical Services Health Plan OPERATED BY SUNSHINE HEALTH