



Send completed form by fax or email to the following:

CMS Provider Management

Fax: (850) 487-1279

Email: cmsproviderhelp@doh.state.fl.us

Letter of Transfer Agreement for Hospitalization of CMS Patients

For physicians without admitting privileges at a Florida licensed hospital.

I, _____
Transferring Physician – Type or Print Name

understand that I am required as a CMS approved physician to provide 24-hour, 7 day a week health care access for my CMS patients. Therefore, I have entered into an agreement with **one** of the following:

Approved CMS Physician who has admitting privileges.

The physician named below is a CMS approved physician who has admitting privileges at a Florida licensed hospital.

The below named physician agrees to admit and oversee in-patient care for CMS enrollees assigned to me who require hospitalization.

_____/_____
CMS Admitting Physician Signature / Type or Print Name / Date

_____(Florida licensed hospital name)

The hospital named above agrees to use employed Pediatric Hospitalists to admit and oversee in-patient care for CMS enrollees assigned to me who require hospitalization.

_____/_____
Hospital Faculty Signature / Type or Print Name / Date

By instituting this agreement, I affirm my desire to ensure that all children with special health care needs enrolled in CMS have a medical home with an assigned CMS primary care provider and have access to a continuum of services within the CMS network of providers.

Transferring Physician Signature / Date