Superior HealthPlan
DME Preferred Provider Opt-Out Form

I, _____ (enter name), would like to opt out of the Superior HealthPlan Durable Medical Equipment (DME) preferred provider program. I would like _____ (Name of DME company) to provide the DME items that are being requested on my behalf. I understand that medical supplies ordered from non-preferred DME providers will require prior authorization based on a review for medical necessity.

_____ _____
Member Signature Date

_____
Member Printed Name

_____
Superior Member ID Number

This form is valid for one year from the date of signature. Members may submit an opt-out form annually if they would like to continue to opt-out of the DME preferred provider program.

NOTE TO PROVIDER: Please submit this form to Superior HealthPlan with your request for prior authorization.

SAVE FORM