



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.