

Health Tradition Health Plan

Durable Medical Equipment Request

This authorization does not guarantee benefits or eligibility. Services and facilities are subject to plan benefits, limitations and exclusions.

Insurance Plan

Premier Premier Plus BC Standard BC Benchmark Other _____

Patient Name: _____ DOB: _____

Insured Name: _____

Insured Phone #: _____ Insured I.D. #: _____

Insured Address: _____

Equipment Prescribed: _____

Code(s): _____ Date of Service: _____

Reason for Need: _____

Estimated Length of Necessity _____ Rent _____ Cost/Month: _____
 Purchase _____ Cost: _____

Comments/Additional Information

Prescribing Practitioner: _____ Date: _____

Area Below is For Health Tradition Use Only:

Comments: _____

_____ Approval _____ Denial Date: _____ Signature: _____