



MEDICAL ASSOCIATES

HEALTH PLANS®

Durable Medical Equipment Pre-Authorization

Date: _____

Patient name: _____

Member Number: _____

Date of Birth: _____

Patient Address: _____

Physician: _____

Patient Diagnosis & Code: _____

Medical Equipment Prescription with appropriate HCPC Codes: _____

Price: _____

Supplier's Name & Address: _____

For our **contracted providers**: Will pay at contractual allowable subject to member's contractual limitations and subscriber agreement.

Date Approved: _____

Signature: _____

Return to: Health Care Services
Attention: Prior Authorization
Medical Associates Health Plans, Inc.
1605 Associates Drive
Suite 101
Dubuque, Iowa 52002
Fax: (563) 585-1545 Telephone: (563)584-3275 or 1-800-325-7442