AvMed Embrace better health®

MEDICAL
Direct Member Reimbursement Form

Complete this form to request reimbursement for covered services.

Completion and submission of this form to AvMed is not a guarantee of reimbursement. Claims are subject to limitations, exclusions and other provisions of your Benefit Plan. Applicable reimbursement can only be made payable to the primary card holder only.

☐ **MEDICARE MEMBER** ☐ **COMMERCIAL MEMBER**

MEMBER INFORMATION (Submit a separate form for each family member)		
Member Name: (First, Last, Middle Initial)	Birth Date:	AvMed Member Number
Mailing Address:	Best Number to contact you at: Email:	
Provider's Name	Provider's Telephone Number:	Provider's Tax ID #:

REASON FOR MEDICAL REIMBURSEMENT

☐ Illness OR ☐ Injury? Date of Illness or Injury: Date of Service:

Description of illness or injury. Please include where injury occurred.

Member Signature:	Date Signed:

IMPORTANT CHECKLIST

To ensure timely processing, please review and complete this checklist prior to mailing your request.

☐ Form is completely filled out.

☐ Documents are in English, clear and legible. If not in English, please provide Translated records together with your form.

☐ Attach itemized bill from provider of service. This must include date of service, procedure codes for each service, diagnosis code, a description of the service performed, and the provider's contact information and Tax ID #.

☐ Attach proof of purchase; Sales receipt, a copy of canceled check (front & back) matching the billed services, etc.

☐ Sign and Date form.

Mail this completed form and all documents to:

AvMed
Attention: Member Reimbursement
P.O. Box 569008
Miami, FL 33256

You can also fax the completed forms and supporting documents to: 305-671-4736

Please allow 45 business days for processing