



Member Claim Form

The attached Member Claim Form is being provided to ensure prompt and accurate processing of your claim. Any omitted information may delay the processing of your claim. Please be advised that non-covered items or services are not reimbursable. For a list of exclusions and limitations, please refer to your Evidence of Coverage. All requests for reimbursement will be processed using Medicare approved rates. You may be responsible for any charges that exceed these rates.

Along with the completed form, please enclose an itemized bill from the provider of service and proof of payment. The itemized bill must include the procedure code of each service(s) performed, fee charged for each service, diagnosis code, provider's full name, address, phone number and tax ID number.

If the charges were for prescriptions drugs, please attach the original receipts from the Pharmacy including proof of payment. The receipts must include the name of the drug, the drug's NDC code, the prescription number, the date of fill, and the amount charged. The pharmacy usually attaches this information to the bag the prescriptions come in.

If you need help filling out this form or you are being billed for amounts above your co-payment, deductible and/or applicable coinsurance, please contact AvMed Member Services at 1-800-782-8633. Our representatives are available 24 hours a day, 7 days a week. TTY users may call 1-877-866-5432 Monday through Friday from 8:30 a.m. to 5:00 p.m.

Submit the Completed Member Claim Form, receipts, and proof of payment to:

AvMed Health Plans
Attention: Member Services
(Member Reimbursement)
P.O. Box 823
Gainesville, FL 32602-0823

AvMed is a Medicare Advantage organization with a Medicare contract

THIS FORM MUST BE COMPLETED AND SIGNED

NAME: _____

AVMED MEMBER NUMBER: _____

ADDRESS: _____ APT# _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER: _____

DESCRIBE THE INJURY OR ILLNESS COMPLETELY (IF AN INJURY, DESCRIBE HOW, WHEN, AND WHERE THE INJURY OCCURRED)

IF THE INJURY WAS DUE TO AN AUTO ACCIDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF AUTO CARRIER: _____

CLAIM NUMBER _____

ADJUSTER'S NAME _____ PHONE NUMBER _____

AUTO CARRIER'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____

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REQUESTS FOR MEDICATION REIMBURSEMENT MUST HAVE THE FOLLOWING ATTACHED:

1. CLEAR COPIES OF THE DRUG LABEL/RECEIPTS SHOWING THE FOLLOWING: MEMBER'S NAME, DATE OF FILL, PHARMACY NAME AND LOCATION, NAME OF THE MEDICATION, NDC NUMBER, STRENGTH, QUANTITY, AND AMOUNT PAID FOR THE MEDICATION
2. PLEASE PROVIDE PROOF OF PURCHASE SHOWING THE DATE AND AMOUNT PAID FOR THE MEDICATION. A CASH REGISTER RECEIPT, COPY OF A CANCELLED CHECK, COPY OF A CREDIT CARD BILL, OR PHARMACY PRINTOUT OF PRESCRIPTIONS IS ACCEPTABLE.

PLEASE DESCRIBE WHY YOU PURCHASED THE MEDICATION:

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

THE ABOVE ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY PHYSICIAN, MEDICAL INSTITUTION, DRUGGIST, INSURANCE COMPANY, EMPLOYER, HOSPITAL, LABOR UNION OR ASSOCIATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE TO AVMED HEALTH PLAN AS IS REQUIRED TO PROPERLY PAY ALL BENEFITS, IF ANY, DUE ME FOR THE CLAIM. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE: _____ DATE _____

PLEASE MAIL THE COMPLETED FORM AND ANY ATTACHEMENTS TO THE FOLLOWING ADDRESS:

AVMED HEALTH PLANS
ATTENTION: MEMBER SERVICES
(MEMBER REIMBURSEMENT)
POST OFFICE BOX 823
GAINESVILLE, FL 32602-0823

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