AvMed Embrace better health®

MEDICAL
Direct Member Reimbursement Form
NOTE: Only use this form for medical services.
Please use the *Pharmacy Direct Member Reimbursement* Form for all medications and vaccinations to assure appropriate and timely processing.

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