

Empowering You to Secure Services Under Your Benefit Plan

As a member of AvMed, it's important for you to know that for certain medical procedures, services, or medications, your doctor or hospital needs advanced approval before your plan covers any of the costs.

You, your provider, or your designated representative may submit a request for authorizations of services. Authorizations requests are processed as expeditiously as your health condition requires; however, below are the different types of authorization requests and their processing timeframes.

For existing members, please see your member contract or Evidence of Coverage for a list of services requiring prior authorization. Services requiring Prior Authorization may change from time to time. For more information about which services require Prior Authorization, please contact AvMed's Member Engagement Center at 1-800-882-8633. You should always make sure your Physician contacts us to obtain Prior Authorization.

Prospective members may also contact AvMed's Member Engagement Center for information on plan benefits and authorization requirements.

- **Non-urgent/Standard pre-service request - request is made in advance of the patient obtaining medical care or services.** Decision and notification will be made no later than 15 calendar days after receipt of request for commercial plans and 14 days for the Medicare plans.
- **Urgent/Expedited pre-service request** - medical care provided for illnesses or injuries which require prompt attention based on the definition of urgent/expedited. An expedited request is if the Member's life, health, or ability to regain maximum function could be seriously harmed by waiting for the non-urgent/standard time-period. The decision and notification will be made no later than 72 hours after receipt of the request.
- **Urgent Concurrent** – An on-going course of treatment. The decision and notification will be made no later than 24 hours after receipt of the request.
- **Post-service** - Any request for approval of care or treatment that has already been received by the patient. The decision and notification will be made no later than 30 calendar days of receipt of the request.
- **Appeal**- A request for AvMed to reconsider a decision that denies a request for service or payment. Your denial letter or EOB (*explanation of benefits*) gives directions regarding how to submit an appeal to AvMed. In addition, you can contact AvMed's Member Engagement Department. The number is located on the back of your AvMed Member ID card.