NEW MEMBER TRANSITION-OF-SERVICE FORM

Fax 1-800-552-8633, email: TransitionofService@AvMed.org**, or mail to** AvMed, P.O. BOX 569008, Miami, FL, 33256

This form is to assist newly enrolled members transition their medical services and prescription needs from their previous health plan to AvMed. To assure continued care or treatment please complete and return this form to AvMed by email or fax within the first 30 days of eligibility. Please Complete one form for each family member with transition of service needs and provide the best time for AvMed to contact you during normal business hours. Completion of this form provides AvMed with the information needed to facilitate ongoing care and prescription refill needs.

Some prescription medications on AvMed's formulary have certain requirements for coverage. To view the most current prescription drug list, please visit the AvMed website at www.AvMed.org and click on Preferred Medication Lists. Check this list to confirm the status of your medications. Please indicate the drug name and prescriber's name below if your medication is not listed on our drug list, if it has a "PA" or "ST" written before its name, or if you take an opioid pain medication.

If AvMed requires additional clinical information, we will request records on your behalf from the doctor's information you provide below. Please allow up to two weeks to receive required progress notes from your physician.

If you have any questions regarding this form, please call AvMed's Member Engagement Center at 1-800-882-8633.

Member Information			
Last name	First name	MI	Date of birth
Member ID# or SSN	Phone #	Alternate Phone#	Today's date
Email:		AvMed policy effective date:	
Relationship to Employee: ☐ Self ☐ Other		Employer Group	

Current Ongoing Medical Treatment & Services select all that apply. (Please use page two to add additional information.)

☐ Transplant / Pending Transplant: Date of transplant_____ Provider Name/Phone #_____

☐ Current Dialysis: ☐ Hemodialysis ☐ Peritoneal Provider Name/Phone #_____

☐ Diabetes: Do you have a Blood Glucose meter? Y ☐ N ☐ Provider Name/Phone #_____

☐ Pregnant: Due date_____ High-risk? Y ☐ N ☐ Provider Name/Phone #_____

☐ Home Care: Name of agency _____ Provider Name/Phone #_____

☐ Current Durable Medical Equipment _____ Provider Name/Phone #_____

☐ Other: Illness/Treatment_____

Provider Name_____ Phone #_____

Additional Information:

Prescription Medication. (Please use page two to add additional information.)

Prescriber's Name:_____ Prescriber's Phone Number: _____

Drug Name Drug Name

Prescriber's Name:_____ Prescriber's Phone Number: _____

Drug Name Drug Name

Prescriber's Name:_____ Prescriber's Phone Number: _____

Drug Name Drug Name

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider to release for review me or my enrolled dependent children's (under the age of 18) medical records to AvMed. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children for treatment, payment, and health care operations.

X_____

Member Signature Date

Additional Current Ongoing Medical Treatment & Services.
Additional Information:

Additional Prescription Medication.	
Prescriber's Name: _____	Prescriber's Phone Number: _____
Drug Name	Drug Name
Prescriber's Name: _____	Prescriber's Phone Number: _____
Drug Name	Drug Name
Prescriber's Name: _____	Prescriber's Phone Number: _____
Drug Name	Drug Name
Prescriber's Name: _____	Prescriber's Phone Number: _____
Drug Name	Drug Name
Prescriber's Name: _____	Prescriber's Phone Number: _____
Drug Name	Drug Name

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