AvMed Embrace better health.

## *AVMED VERIFICATION FORM*

Dear AvMed Patient:
Our records show you are not on our AvMed eligibility list. You will receive services today with the understanding that you may be billed and held financially responsible in the unlikely event that your coverage is not effective for one of the following reasons:

- Your membership has lapsed
- The services are not a covered benefit
- You have selected a different Primary Care Physician this month
- Your enrollment application is still being processed, has not been received or cannot be verified by AvMed.

I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY TO DOCTOR _____.
I HEREBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGEMENT OF THIS UNDERSTANDING. I AUTHORIZE AVMED TO DESIGNATE THIS PHYSICIAN AS MY PRIMARY CARE PHYSICIAN AS OF TODAY'S DATE.

_____ _____
Patient's Signature/Date Office Staff Signature/Date

_____ _____
Patient's Name (Please Print) Employer/Group Name (If Applicable)

_____ _____
AvMed ID Number AvMed Provider Number
(If not sure, use *Subscriber's SS#)
*SUBSCRIBER IS THE PERSON WHO WORKS FOR THE EMPLOYER WHO OFFERS AVMED COVERAGE**.**

**TO PHYSICIAN'S OFFICE**: AvMed members who are required to select a PCP and are not on your eligibility list should sign this form. Mail or fax forms to AvMed so that your eligibility listing can be updated.

**Mail: AvMed Health Plans**
**Attn: Member Services**
**P.O. Box 569008**
**Miami, FL 33256**

**Fax: (352) 337-8612**