PROVIDER INTEREST FORM

This form is for New Providers only. Existing practices please contact the Provider Service Center at 1-800-452-8633.

AVMED OFFERS PROVIDERS
these great benefits:

Fast Service & Easy Access to Your Claims
- Direct deposit & fast claims payments

Tradition of Quality Health Care
- Strong physician satisfaction

Access to Physician Support
- Local medical directors
- Care management programs

BEHAVIORAL HEALTH, CHIROPRACTIC, PODIATRY AND VISION:
To inquire about participation with AvMed, please use the contact information below.

Specialty Type:	Contact:	Phone:
Behavioral Health Specialists (all Florida)	Magellan Healthcare	Phone: 1-800-788-4005 Web: MagellanHealth.com/provider
Chiropractic	Chiro Alliance Corp. (CAC)	Phone: 727-319-6199
Podiatry*	Podiatry Network Services (PNS)	Phone (Local): 786-924-0044 Phone Toll Free: 1-844-222-3939 Fax: 1-800-552-8633
Optometry	iCare Health Solutions	Email: Providers@MyiCareHealth.com Web: MyiCareHealth.com/Portal/InfoRequest_ichs.aspx

For all other specialties, including Primary Care Physicians, Specialists, Hospital-Based Physicians, Ancillary Providers and Facilities, please complete the form on the reverse side and fax along with a complete, current and signed W-9.

Central & North Florida
(Tampa, Orlando, Gainesville, Jacksonville):
Fax: 1-888-430-9394
Phone: 1-800-452-8633

South Florida (Miami-Dade, Broward, Palm Beach, Martin and St. Lucie):
Fax: 1-800-518-4443
Phone: 1-800-452-8633

Submission of this form does not guarantee participation in the network. Decisions are based on network need and credentialing criteria. We will contact you if there is an opening, otherwise we will maintain your information and contact you in the future should our needs change.

* Not available in Alachua, Bradford, Suwannee, Sarasota or Lee County.

PROVIDER INTEREST FORM

Please note, This form is for New Providers only. If you are joining a participating AvMed practice, please contact the AvMed Provider Service Center at 1-800-452-8633.

PROVIDER INFORMATION

First Name | Middle Initial | Last

Degree | Date | Facility Name/Name of Physician Group | Accreditations

Tax ID# | Group/Individual NPI | Contact Person

Primary Office Address* | City | Zip | Primary County

Office Hours | Phone# | Fax #

E-Mail

* Any additional locations must be submitted on letterhead with address, phone, fax and office hours.

PROVIDER TYPE/DESCRIPTION (CHECK ONE)

☐ Primary Care/Specialists: Family Practice, Internal Medicine, Pediatrics ☐ Group Practice ☐ Solo Practitioner
Specialty: _____ Board Certified: Yes ☐ No ☐ Board Eligible: Yes ☐ No ☐

☐ Hospital-Based: Anesthesiology, Emergency Medicine, Pathology, Radiology, Neonatal-Perinatal Medicine
☐ Group Practice ☐ Solo Practitioner

☐ Hospital / Ancillary Service Provider
(ASC, Diagnostic Testing Facilities, PT/OT/ST, SNF, Urgent Care, Other _____)

☐ Utilize Electronic Health Records (EHR/EMR): Yes ☐ No ☐ If yes, EHR/EMR Vendor: _____

Primary Hospital Affiliation | CAQH ID# (if applicable):

Other Hospital Affiliations

Group Name | Partner Names

List other physicians or any ARNP's/PA's rendering services in your office(s): _____

Please make sure this form is completely filled out and legible. Please return this form along with a complete, current and signed W-9. This form does not guarantee participation in the network. Applicants must meet all credentialing criteria and other participatory criteria.