AvMed Directory Information Change Form

Please complete this form and return as soon as possible to have your directory changes reflected on the AvMed website and in the printed directories.

Fax to **305-671-6149**

or mail to: **AvMed Health Plans**
Provider Service Center
3470 NW 82nd Avenue
Ste 1100
Doral, FL 33122

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1. *Please fill in ALL information in this section. Make Address corrections on next page.*

Provider Name _____
(As it should appear in the directory. Use middle initial if desired)

Provider AvMed # _____ **Provider Tax ID #** _____

Specialty _____
(Heading in the directory under which your name should appear)

Contact Name _____ **Phone#** _____

Person authorized to make these changes _____

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2. *Fill in ONLY the information that should be changed.*
Fill in the parentheses as follows: **(A)** for Addition **(D)** for Deletion **(C)** for Change

( ) Panel Comments _____
(Age restrictions and/or other panel comments)

( ) Board Certified (Year) _____
(Attach a copy of certificate)

( ) Group Practice Name | | | | | | | | | | | | | | | | | | | | | | | | |
(Please abbreviate. Field is limited to 24 characters)

( ) Group Practice Name | | | | | | | | | | | | | | | | | | | | | | | | |

( ) Languages _____

Your comments _____

_____

_____

AvMed Directory Information Change Form - *continued*

Fill in ONLY the information that should be changed.

Fill in the parentheses as follows: **(A)** for Addition **(D)** for Deletion **(C)** for Change

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First Location: **County** _____

( ) Provider Address _____ **( ) Suite** _____

( ) City _____ **( ) State** _____ **( ) Zip** _____

( ) Phone _____ **( ) Fax** _____ **( ) Email** _____

( ) Office Hours _____

Second Location: **County** _____

( ) Provider Address _____ **( ) Suite** _____

( ) City _____ **( ) State** _____ **( ) Zip** _____

( ) Phone _____ **( ) Fax** _____ **( ) Email** _____

( ) Office Hours _____

Third Location: **County** _____

( ) Provider Address _____ **( ) Suite** _____

( ) City _____ **( ) State** _____ **( ) Zip** _____

( ) Phone _____ **( ) Fax** _____ **( ) Email** _____

( ) Office Hours _____

Fourth Location: **County** _____

( ) Provider Address _____ **( ) Suite** _____

( ) City _____ **( ) State** _____ **( ) Zip** _____

( ) Phone _____ **( ) Fax** _____ **( ) Email** _____

( ) Office Hours _____
