AvMed Embrace better health®

PHARMACY
Direct Member Reimbursement Form

Complete this form to request reimbursement for medication you purchased.

Completion and submission of this form to AvMed is not a guarantee of reimbursement. Claims are subject to limitations, exclusions and other provisions of your Benefit Plan. Applicable reimbursement can only be made payable to the primary card holder only.

☐ MEDICARE MEMBER ☐ COMMERCIAL MEMBER

MEMBER INFORMATION (Submit a separate form for each family member)		
Member Name: (First, Last, Middle Initial)	Birth Date:	AvMed Member Number
Mailing Address:	Best Number to contact you at: Email:	
Prescribing Physician's Name	Prescribing Physician's Telephone Number:	

REASON FOR MEDICAL REIMBURSEMENT	
☐ Out of Area Emergency Medication	☐ Did not have AvMed Member Id Card
☐ Coordination of Benefits (AvMed is Secondary)	☐ Member not found in Pharmacy System
☐ Claim Denied	☐ Other
Member Signature:	Date Signed:

IMPORTANT CHECKLIST

To ensure timely processing, please review and complete this checklist prior to mailing your request.

☐ Form is completely filled out.

☐ Documents are in English, clear and legible. If not in English, please provide Translated records together with your form.

☐ Attach itemized bill which is usually included with the medication. It must include the fill date, pharmacy name, pharmacy location, quantity filled, prescriber's name, and amount paid.

☐ Attach proof of purchase; Sales receipt, canceled check, etc.

☐ Sign and Date form.

Mail this completed form and all documents to:
AvMed
Attention: Member Reimbursement
P.O. Box 569008
Miami, FL 33256

You can also fax this completed form and supporting documents to: **1-352-337-8737**

Please allow 45 business days for processing