

AWAY FROM HOME PROGRAM (AFH) STATE OF FLORIDA



If you have covered dependents, including students who are away at school or do not live with you on a regular basis, please read below:

AvMed offers Members who live within the AvMed Service Area (see below) access to a nationwide provider network through Private Healthcare Systems, Inc. (PHCS), for covered dependents who reside outside the AvMed Service Area on a temporary basis. This includes students away at school and shared custody arrangements. Your covered dependents may use PHCS providers and receive the in-network benefit level. To determine if PHCS providers are available where your dependent resides or attends school, please check the website at www.avmed.org/web/individuals-families/tools-resources/phcs-multiplan-consent.

Please complete the Away From Home form to obtain dependent access to PHCS network. All required plan procedures and guidelines must still be followed for claims to be approved for payment.

For additional information, please contact AvMed's Member Engagement Center at **1-888-762-8633**.

AVMED SERVICE AREA:

The AvMed network is available in the following regions / counties (Members may have access to PHCS network outside these service areas):

Region	Counties
South Florida	Broward, Miami-Dade, Palm Beach
West Florida	Hernando, Hillsborough, Lee, Pasco, Pinellas, Polk, Sarasota
North/Central Florida	Alachua, Baker, Bradford, Brevard, Charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Dixie, Duval, Flagler, Gilchrist, Glades, Hamilton, Hendry, Highland, Indian River, Lake, Levy, Madison, Manatee, Marion, Martin, Nassau, Okeechobee, Orange, Osceola, Putnam, Seminole, St. Johns, St. Lucie, Suwannee, Taylor, Union and Volusia

TO ENROLL YOUR DEPENDENT(S), PLEASE COMPLETE THE INFORMATION BELOW AND:

Fax it to: Attn: Member Engagement
305-671-4736

Or mail it to: AvMed, Attn: Member Engagement
P.O. Box 569008, Miami, FL 33256

ENROLL INFORMATION:

Name of Associate: _____ **Associate ID or SS#:** _____

Associate signature: _____ **Date signed:** _____

DEPENDENT(S) TO BE ENROLLED ON AWAY FROM HOME*:

1. Dependent Name: _____ **Associate Name/ID#:** _____

Reason for Away from Home: _____

Effective start and end date requested: _____ **Name of school:** _____

Address of dependent (must include city and state): _____

2. Dependent Name: _____ **Associate Name/ID#:** _____

Reason for Away from Home: _____

Effective start and end date requested: _____ **Name of school:** _____

Address of dependent (must include city and state): _____

For additional dependents, please complete another form.