AvMed Embrace better health

Specialty Medication Delivery Program
Physician Dis-Enrollment Form

(If additional physicians in your group want to dis-enroll from this program, please copy this form and have each physician submit their own request on a separate copy of this form.)

Complete all requested information (please print clearly):

Physician's Name:

Address:

City: **Zip:**

Physicians Telephone #:

Physician's Facsimile #:

Physician's AvMed Provider #:

Physician's DEA #: **NPI#:**

Physician's Specialty:

Contact Person's Name:

Contact Person's Telephone #:

(if different from physician's)

Contact Person's Fascimile #:

(if different from physician's)

By completion of this form and by my signature below, I am indicating my desire to dis-enroll from AvMed Health Plans' Specialty Medication Delivery Program..

Physician's Signature (required)**:**

Date Signed (required)**:**

Fax Completed Enrollment Form to 352.337.8737

This section is for AvMed's use only.
Date notified: ☐ Pharmacy Dept. ☐ CVS Caremark ☐ Physician

Your dis-enrollment in the **Specialty Medication Delivery Program** will become effective

on: _____.

Use the following form to order replacement drugs from CVS Caremark.