On-Call Relationship Form

Completion of this form is essential to ensuring that practitioners who provide on-call coverage for your Medicare members will have their claims processed using your referral on file. Please notify AvMed as soon as any of these practitioners are no longer providing on-call coverage to your members.

AUTHORIZED PROVIDER INFORMATION:

Provider Name: _____ Provider #: _____

Practice Name: _____ Practice #: _____

Tax ID #: _____

PROCESS FOR ON-CALL COVERAGE FOR: ☐ Individual Provider ☐ Group Practice

Covering Provider: _____ Provider #: _____

Practice Name: _____ Practice #: _____

Tax ID #: _____

I hereby certify that I have the authority to submit this On-Call relationship Form on behalf of _____. I further certify that all the information provided herein is accurate and that my signature below shall have the legal effect of all representations herein being made under oath. I hereby acknowledge that the information on this Provider Request Change Form is being provided as part of the AvMed HMO provider application and/or contract process for the payment of covered services. I hereby acknowledge that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement related to a claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree and may be subject to other criminal and/or civil actions.

Provider Printed Name: _____

Provider Signature: _____ Date: _____

INSTRUCTIONS:

Fax completed form to Provider Service Center at 305-671-6149 or toll free 1-877-231-7695.