

AWAY FROM HOME PROGRAM

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 access to a nationwide provider network through Private Healthcare Systems, Inc. (PHCS) for those members who live within the AvMed Service Area (see below) and have covered dependents who reside outside the AvMed Service Area, including students away at school. Your covered dependents may use PHCS providers and receive the in-network level of benefits. To determine if there are PHCS providers available in the area where your dependent resides or attends school, please check the website at <http://www.avmed.org/go/mdpht>. **To provide access to this network for your dependents, please complete AvMed's Away From Home form. AvMed will provide an additional identification card that will allow your dependent access to the PHCS national network while they are not living in your home.** For additional information, please visit a regional meeting during Open Enrollment or AvMed's website at <http://www.avmed.org/go/mdpht>. You may also contact AvMed's M-DC/JHS Dedicated Member Services Unit at 1-800-682-8633.

AvMed Service Area

The AvMed network is available in the following regions / counties: *

Region	Counties
South Florida	Broward, Miami-Dade, Palm Beach
West Florida	Hernando, Hillsborough, Lee, Pasco, Pinellas, Polk, Sarasota
North/Central Florida	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Gilchrist, Hamilton, Lake (7 zip codes only: 34711, 34712, 34713, 34714, 34715, 34736 & 34756), Levy, Marion, Nassau, Orange, Osceola, Seminole, St. Johns, Suwannee, Union

*Members may have access to the PHCS network outside these service areas.

To enroll your dependent(s) in this program, please complete the information below and mail it in the enclosed stamped self-addressed AvMed envelope to the following address: AvMed Health Plans, Attention: On Call, P.O. Box 569004, Miami, FL 33256-9942.

Employee Name: _____ **Employee SS #:** _____

Name(s), Relationship(s) and Addresses of Covered Dependents who will not reside with you for most of the calendar year for whom you would like to provide additional network access:

- (1) Dependent Name: _____
 Relationship to Employee: _____
 If student, please identify school: _____
 Address, if known, of dependent (must include city and state): _____

- (2) Dependent Name: _____
 Relationship to Employee: _____
 If student, please identify school: _____
 Address, if known, of dependent (must include city and state): _____

- (3) Dependent Name: _____
 Relationship to Employee: _____
 If student, please identify school: _____
 Address, if known, of dependent (must include city and state): _____

For additional dependents, please add them on the back of this form.