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:<br><br>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**