

CLAIM REIMBURSEMENT FORM
INSTRUCTIONS FOR SUBMISSION

The attached Claim Reimbursement form is being provided to ensure prompt and accurate processing of your reimbursement. Reimbursements are made for covered benefits only. Non-covered items or services are not reimbursable. Please refer to your Summary Plan Description for a list of exclusions and limitations. Please be advised that all requests for reimbursement will be processed according to usual and customary fees or AvMed's contracted rate. You may be responsible for any charges that exceed these rates, as well as any applicable deductible, coinsurance, and/or co-payment amounts.

When submitting your claim:

- Complete all the sections on the form.
- If the charges are for a dependent spouse or child, please complete the Dependent section.
- Submit an **itemized bill** from the provider of service. The itemized bill must include the provider's name, address, phone number and tax ID number. In addition, the following information is required for each service performed: the date, the diagnosis, the procedure and the fee charged.
- Attach all your original receipts and proof of payments.
- For prescription medications, the receipt must include the name of the medication, the medication's NDC code, prescription number, date of fill and amount charged. This information is usually found on the receipt that the Pharmacy attaches to the bag in which your medications are dispensed.
- If you are receiving a bill from a provider for amounts above your co-payment, deductible and/or applicable coinsurance, please contact Member Services at **1-800-682-8633**. Our representatives are available to assist you 24 hours a day, seven days a week.

Submit your claim, receipts and proof of payment to:

AvMed Health Plans
Attention: Member Services
(Member Reimbursement)
P.O. Box 823
Gainesville, FL 32602-0823



Member Claim Form

THIS FORM MUST BE COMPLETED AND SIGNED

SUBSCRIBER'S NAME: _____ MEMBER NUMBER: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER (HOME): _____ EMPLOYER: Miami-Dade County/Jackson Health System

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ ADDRESS: _____

DO YOU OR YOUR SPOUSE HAVE COVERAGE WITH ANOTHER PLAN? YES NO

ARE YOU OR YOUR SPOUSE COVERED UNDER MEDICARE? YES NO

IF YOU ANSWERED YES TO EITHER QUESTION, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF PLAN: _____ POLICY NUMBER: _____

EFFECTIVE DATE OF POLICY: _____ PHONE NUMBER: _____

PLAN ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF THE CLAIM IS FOR YOUR DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DEPENDENT'S NAME: _____ DATE OF BIRTH: _____

AVMED MEMBER NUMBER: _____ RELATIONSHIP: CHILD SPOUSE

IS THE DEPENDENT COVERED BY ANOTHER PLAN? YES NO IF YES, PROVIDE THE FOLLOWING:

NAME OF PLAN: _____ POLICY NUMBER: _____

EFFECTIVE DATE OF POLICY: _____ PHONE NUMBER: _____

PLAN ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DESCRIBE THE INJURY OR ILLNESS COMPLETELY (IF AN INJURY, DESCRIBE HOW, WHEN AND WHERE THE INJURY OCCURRED). _____

PLEASE SUBMIT LEGIBLE COPIES OF ALL DOCUMENTS.

1. REQUESTS FOR REIMBURSEMENT OF MEDICAL SERVICES MUST INCLUDE AN ITEMIZED BILL WITH DETAILED INFORMATION, INCLUDING DIAGNOSIS AND PROCEDURES, DATE OF SERVICE, PROVIDER INFORMATION (PROVIDER NAME, ADDRESS, PHONE NUMBER, TAX ID), CHARGES AND ANY PAYMENTS ALREADY MADE.
2. FOR PHARMACY REIMBURSEMENTS, PLEASE SUBMIT LEGIBLE COPIES OF THE DRUG LABEL/RECEIPTS SHOWING THE FOLLOWING: MEMBER'S NAME, DATE OF FILL, PHARMACY NAME AND LOCATION, NAME OF THE MEDICATION, NDC NUMBER, STRENGTH, QUANTITY AND AMOUNT PAID FOR THE MEDICATION. YOU MUST ALSO PROVIDE PROOF OF PURCHASE SHOWING THE DATE AND AMOUNT PAID FOR THE MEDICATION. A CASH REGISTER RECEIPT, COPY OF A CANCELLED CHECK, COPY OF A CREDIT CARD BILL OR PHARMACY PRINTOUT OF PRESCRIPTIONS IS ACCEPTABLE.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

I AUTHORIZE ANY PHYSICIAN, MEDICAL INSTITUTION, DRUGGIST, INSURANCE COMPANY, EMPLOYER, HOSPITAL, LABOR UNION OR ASSOCIATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE TO AVMED HEALTH PLAN AS IS REQUIRED TO PROPERLY PAY ALL BENEFITS, IF ANY, DUE ME, MY SPOUSE, OR OTHER DEPENDENT FOR THE CLAIM. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

I CERTIFY THAT ALL INFORMATION PROVIDED IS ACCURATE AND COMPLETE. I FURTHER UNDERSTAND THAT ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

SUBSCRIBER'S SIGNATURE: _____ DATE: _____

SPOUSE'S SIGNATURE (if applicable): _____ DATE: _____

PLEASE MAIL THE COMPLETED FORM TO THE FOLLOWING ADDRESS:

AVMED HEALTH PLANS
ATTENTION: MEMBER SERVICES
(MEMBER REIMBURSEMENT)
POST OFFICE BOX 823
GAINESVILLE, FL 32602-0823

FAILURE TO PROVIDE COMPLETE INFORMATION MAY DELAY THE PROCESSING
OF YOUR REQUEST FOR REIMBURSEMENT