



## **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 Certificate of Coverage or 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 rates. You may be responsible for any charges that exceed these rates.

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 **1-800-882-8633**. 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: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  WIDOWED  DIVORCED

SPOUSE'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS NUMBER \_\_\_\_\_

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 \_\_\_\_\_

### IF THE CLAIM IS FOR A CHILD AND THE CHILD IS 19 OR OLDER, IS THE CHILD A FULL-TIME STUDENT?

YES  NO; IF YES, NAME OF SCHOOL \_\_\_\_\_

IS THE CHILD EMPLOYED?  YES  NO IF YES,  PART TIME  FULL TIME

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

1. CLEAR 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
2. PLEASE 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 DESCRIBE WHY YOU PURCHASED THE MEDICATION: \_\_\_\_\_

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PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

THE ABOVE ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. 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.

SUBSCRIBER'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE'S SIGNATURE: \_\_\_\_\_ 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