



Medicare Member Reimbursement Form

Name: _____ Member Number: _____

Home Address: _____

City _____ State _____ Zip _____ Phone Number (Home): _____

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For Medical Reimbursement [Complete This Section Only]

Was this for an _____ Injury or _____ Illness Date of Injury/Illness: _____

Describe Injury/Illness: (if Injury, include where injury occurred)

Please include the following documentation:

- Itemized bill from the provider of service(which include - procedure code of each service(s), diagnosis code, provider’s contact information)
- Proof of payment (sales receipt, cancelled check, etc.).

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For Medication Reimbursement [Complete This Section Only]

Provide reason for out-of-pocket payment for this medication:

Please include the following documentation:

- Original pharmacy receipt(s) and the pharmacy label (usually included with medication and must have the fill date, pharmacy name and location, quantity, and amount paid).
- Proof of Purchase (sales receipt, cancelled check, etc.)

Member’s Signature: _____ Date _____

Please mail the completed form to the following address:

AvMed Health Plans
Attention: Member Reimbursement
P.O. Box 569008
Miami, FL 33256

Failure to provide complete information may delay the processing of your request for reimbursement.