

Order Form

Please complete this form and return as soon as possible.

Fax: **305-671-6149**
 Toll-free Fax: **1-877-231-7695**

or mail to: **AvMed Health Plans**
Provider Service Center
9400 S. Dadeland Blvd. Ste 420
Miami, Florida 33156

1. Please fill in all information in this section.

Person Requesting _____

Phone Number _____ Best time to call _____

Provider AvMed # _____ Provider Tax ID # _____

Provider Name _____

Mailing Address _____ Suite _____

City _____ State _____ Zip _____

2. Please fill in quantities requested if applicable.

- | | | |
|----------|-------|--|
| MP-5366 | _____ | Advance Directives/Allergy Stickers |
| MP-1445 | _____ | Advance Directives Member Pamphlet |
| MP-1437 | _____ | Authorization Request Form |
| MP-1538 | _____ | AvMed Link Referral Sheet (Pad) |
| MP-1056 | _____ | Envelopes - Attn: Claims Dept. (yellow) |
| MP-1058 | _____ | Envelopes - Attn: Claims Review & Appeal Dept. (pink) |
| MP-1435 | _____ | Lead Screening Labels - For Medical Records Documentation |
| MP- 3160 | _____ | Medication Exception Request Form |
| MP- 2118 | _____ | Prenatal Care Assessment Stickers |
| MP-1843 | _____ | Problems and Medication Summary (Pad) - For Medical
Records Documentation |
| MP- 2105 | _____ | Request For Claims Review/Appeal |
| MP- 2106 | _____ | Request For Claims Status |
| GP-1062 | _____ | Allergy Stickers (for outside your Medical Record) |
| | _____ | Network Directory |
| | _____ | Physicians Reference Guide |
| | _____ | Office Orientation |