

**AvMED**  
HEALTH PLANS  
Provider Interest Form

**Hospital Based & Ancillary Providers Submit This Form To:**

Fax: 352-337-8505 E-Mail: provider.inquiry@avmed.org  
Mail: Ancillary Contracting, 4300 NW 89th Blvd, Gainesville, FL 32606  
(For Pharmacy Interest Forms, please fax to 352-337-8737)

**All Other Providers Submit This Form To:**

Miami/Dade Fax: 305-671-6138 Gainesville Fax: 352-337-8947  
Broward/Palm Beach Fax: 954-627-6220 Jacksonville Fax: 904-858-1355  
Tampa/Orlando Fax: 813-281-0659

**Provider Information:**

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Office Address: \_\_\_\_\_ Tax ID #: \_\_\_\_\_  
\_\_\_\_\_  
Group/Individual NPI: \_\_\_\_\_  
\_\_\_\_\_  
Primary County: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Other Location(s): \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Back Line #: \_\_\_\_\_  
Fax #: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Provider Type/Description (Check one):**

- Hospital Based Physician/Group: \_\_\_\_\_  
(Anesthesiology, Emergency Medicine, Pathology, Radiology, Neonatal-Perinatal Medicine)
- Ancillary Service Provider: \_\_\_\_\_  
(ASC, Diagnostic Testing Facilities, PT/OT/ST, etc.)
- Primary Care/Specialists: \_\_\_\_\_  
(Family Practice, Internal Medicine, Pediatrics, Other)

CAQH ID# (if applicable): \_\_\_\_\_

Primary Hospital Affiliation: \_\_\_\_\_

Other Hospital Affiliation(s): \_\_\_\_\_

Diagnostic Treatment Facilities Used: \_\_\_\_\_

Ambulatory Surgery Centers Used: \_\_\_\_\_

Group Name: \_\_\_\_\_

Partner Names: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

Please make sure this form is completely filled out and legible. Submission of this form does not guarantee participation in the network.