

**INSTRUCTIONS FOR COMPLETING FORM**

1. Submit legible copies of CMS 1500 or UB92 form to process your request accordingly.
2. Check the most appropriate box below for type of review requested.
3. Use only one form per review type/per member. You may attach more than one claim per review type.

**PLEASE PRINT**

MEMBER IDENTIFICATION NUMBER	MEMBER NAME
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	FIRST: _____
	LAST: _____
	DATE OF SERVICE: ____/____/____
	CLAIM # _____

Date of Request: \_\_\_\_\_

**Fax Your Request To:**  
**(800) 452-3847**

OR

**Mail To: (Statewide)**

**AvMed Health Plans**  
**P O Box 569004**  
**Miami, FL 33256-9004**

FROM: CONTACT PERSON	PHONE	FAX
PROVIDER NAME	PROVIDER NUMBER	
ADDRESS		
CITY	STATE	ZIP
TAX ID#		

**Corrected Claim**

A corrected claim is enclosed for:

- Units
- Service Code (CPT / HCPCS / REVENUE CODE)
- Member ID Number
- Other Correction (please describe below)
- Implant / Prosthetic Device  
(Invoice or purchase order enclosed)

Cost: \$ \_\_\_\_\_ + \_\_\_\_\_ % = \$ \_\_\_\_\_ expected reimbursement

**Claim Paid Incorrectly**

- Units Paid Incorrectly
- Payment Sent To Wrong Address
- Payment Made To Wrong Provider
- Payment Not Correct According To Contract
- DME: Purchase Authorized, Rental Paid

**Other:** (Describe request in detail)

**Authorization Denial**

- Claim denied for "no auth" but services do not require an authorization
- Services were authorized, please review  
Authorization # \_\_\_\_\_
- Specific services were not authorized, but were medically necessary  
(See enclosed appeal letter and supporting documentation describing the situation)

**Other Denial**

- Consult Report Not Received  
(See enclosed consult report)
- Member Is Not Assigned To Your Panel  
(Proof of member assignment dates enclosed)
- Member Not Eligible At Time Of Service  
(See enclosed eligibility documentation)
- Untimely Filing  
(See enclosed appeal letter describing the situation)
- Lack Of COB Information  
(COB form signed by member is enclosed)
- Service Covered Under Capitation

**NOTE:** Your contract allows a specified time period to request a review. This date is calculated from the date of the original notice of payment or denial on the explanation of payment report. Late claim reviews or appeals cannot be considered.

TO REORDER ADDITIONAL FORMS CALL THE PROVIDER SERVICE CENTER AT 1-800-452-8633.