

REQUEST FOR CLAIM STATUS



INSTRUCTIONS FOR COMPLETING FORM

- Submit legible copies of CMS 1500 or UB92 form to process your request accordingly, *OR*
- Please enter the claims information on this form.

Please Print

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

Date of Request:

Fax Your Request To:
(800) 452-5182

OR Mail To:
P O Box 569004
Miami, FL 33256-9004

For AvMed Use Only

Member ID #	Member Name	DOS	Amount Billed	Paid Amount or Denial Code Description	Check Number	Check Date

Comments:

REMINDER: 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.

Claims Service Rep: _____

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