

**Please Sign & Fax or Mail To:**

AvMed Health Plans  
Provider Service Center  
P.O. Box 569004  
Miami, FL 33256-9942  
Fax (305) 671-6149 or (877) 231-7695



# Direct Deposit Authorization Form

**AvMed will EFT (direct deposit) your claim payments DIRECTLY into your bank account!**  
**We will also DELIVER your RA or EOP directly to your eMail Inbox as a PDF attachment!**  
**“No Links, No Portals, No Downloads, No Kidding!”**

CHECK #: NO CK		CHECK DATE: N/A		<b>PAYEE #</b> PAYEE #: 50321		REPORTING TAX ID #: 593084472									
MEMBER	CLAIM#	SERV MOD CODE	UNITS SERVICE FROM/THRU	RECEIVED DATE	AMOUNT CLAIMED	IN-ELIGIBLE	AMOUNT ALLOWED	COPAY	DEDUCTIBLE	MBR CO INS.	COB OTH PAID	OTHER	INTEREST PAID	AMOUNT PAID	MEMBER PAYS
<b>Provider Name and Number: PATEL, RAVINDRA R (#083507)</b>															
MUNOZ, LILA J PAT#: M01297CS9T00															
A1045009800 (HM) 061815004777 0100 4756 1 11/23-11/23/04 10/03/05															
					2,800.00	2,800.00	2,800.00	.00	.00	.00	.00	.00	.00	.00	.00

<b>PAYEE NAME (Legal Entity)</b>	<b>PAYEE NUMBER</b>	<b>TAX IDENTIFICATION NUMBER</b>
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<b>EMAIL ADDRESS (Finance Dept Only)</b>	<b>PHONE NUMBER</b>	<b>CONTACT FIRST AND LAST NAME</b>
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A password reset PDF will be sent to the eMail above for you to create a “permanent” password that will secure your eMail delivered RA’s or EOP’s. Please allow up to 10 days for approval. Please check your Spam Filter/Folder for this eMail.

<b>BANK NAME</b>	<b>NAME ON ACCOUNT</b>	<b>ROUTING NUMBER</b>	<b>ACCOUNT NUMBER</b>
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**ATTACH A VOIDED CHECK**  
**(Voided Check is Required)**

Authorization is hereby given to AvMed Health Plans to credit said account at the financial institution named above for the purposes of transferring AvMed Health Plans payments. AvMed Health Plans is also granted authorization to correct funds erroneously deposited and other necessary debit/credit entries. This Authorization is to remain in effect until notification is given to AvMed Health Plans in writing (requires at least 10 days notice) on an AvMed Health Plans Direct Deposit Authorization Form advising of a change, allowing reasonable time to implement such changes.  
**If you have any questions, please call AvMed Provider Services Center at (800) 452-8633**

<b>AUTHORIZED SIGNATURE</b>	<b>PRINTED NAME AND TITLE</b>	<b>DATE</b>
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