

AvMED

HEALTH PLANS

PLAN ADMINISTERED BY AVMED

EMPLOYEE BENEFITS – CLAIM FORM

Please complete all questions and sign form

EMPLOYER NAME _____	
EMPLOYEE/SUBSCRIBER'S NAME _____	DATE OF BIRTH _____
HOME ADDRESS _____	CITY _____ STATE _____ ZIP _____
PHONE # _____	AVMED ID NUMBER OR S.S. NUMBER _____
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
IF MARRIED, NAME OF SPOUSE _____	SPOUSE'S EMPLOYER _____
ADDRESS _____	
IF CLAIM IS FOR YOUR DEPENDENT, COMPLETE THIS SECTION:	
DEPENDENT'S NAME _____	RELATIONSHIP _____
DEPENDENT'S MEMBER ID NUMBER _____	DATE OF BIRTH _____
DESCRIBED INJURY OR ILLNESS COMPLETELY. (IF INJURY, DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED)	

IS THIS CLAIM A RESULT OF A WORK-RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANY OTHER GROUP INSURANCE PLAN, INCLUDING MEDICARE, WHICH MAY COVER ALL OR PART OF THIS CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE NAME OF INSURANCE COMPANY, ADDRESS, AND POLICY/MEMBER ID NUMBER.	

ATTACH AN ITEMIZED BILL INCLUDING DATE(S) OF SERVICE, DIAGNOSTIC AND PROCEDURE CODES, AND PROOF OF PAYMENT (IF REIMBURSEMENT REQUESTED) TO THE AVMED CLAIMS CENTER NEAREST YOU:	
AVMED HEALTH PLANS	
ATT: MEMBER SERVICES	
(Member Reimbursement)	
POST OFFICE BOX 823	
GAINESVILLE, FL 32602-0823	

the above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, hospital, labor union, or association to release any information regarding the medical history, treatment, disability, or benefits payable to AvMed Health Plans as is required to properly pay all benefits, if any, due me, my spouse, or other dependent for the claim. A photostat of this authorization shall be as valid as the original.

PLEASE SIGN HERE

EMPLOYEE/SUBSCRIBER SIGNATURE _____ DATE _____

SPOUSE'S SIGNATURE, IF APPLICABLE _____ DATE _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony, punishable as provided by Florida statutes.

MP-3338 (2/06)