



**SELF-FUNDED OPTIONS  
PLAN ADMINISTERED BY AVMED  
AVMED: 1-800-882-8633**

**EMPLOYEE VISION BENEFITS – 2011 CLAIM FORM  
CITY OF FORT LAUDERDALE**

City Benefits Office (954) 828-5160

Please complete all questions and sign form

**VISION SERVICES HAVE BEEN ADEQUATELY COMPLETED FOR A REIMBURSEMENT OF UP TO \$250:**

To Myself as an Employee

OR

To the Provider of the Vision Services

\_\_\_\_\_ **Print Name**

\_\_\_\_\_ **Print Name**

**Print Name to Appear on Check:** \_\_\_\_\_

**Mailing Address to Send Payment:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / **2011**

**(Employee or Vision Provider Receiving Payment)**

Annual vision benefit limited to \$250 per city medical plan participant. Any person who knowingly and with intent to injure, defraud, or deceive the city or AvMed, 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. 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 reimburse vision benefits due the employee or provider, A photostat of this authorization shall be as valid as the original.

**PLEASE COMPLETE EMPLOYEE BACKGROUND INFORMATION (PRINT CLEARLY)**

**Employee/Subscriber's Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Daytime Phone:** (\_\_\_\_) \_\_\_\_\_ **AvMed ID Number or City ID:** \_\_\_\_\_

**Marital Status:**  Single  Married  Widowed  Divorced

**IF THIS CLAIM IS FOR A DEPENDENT, PLEASE COMPLETE THE FOLLOWING:**

**If Married, Name of Spouse:** \_\_\_\_\_ **Spouse's Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Dependent's Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Dependent's AvMed ID Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**1. Describe services and supplies:** \_\_\_\_\_

**2. Is this claim a result of a work-related injury?**  Yes  No

**3. Are you or your dependents covered under any other group insurance plan, including Medicare, which may cover all or part of this claim?**  Yes  No

**If yes, provide:** \_\_\_\_\_  
(Name of Carrier) (Address) (Policy/Member ID Number)

**Attach an itemized bill to this completed claim form including dates of service, diagnostic and procedure codes for services & supplies, and proof of any payments.**

**MAIL TO: Avmed Health Plans, Attn: Member Reimbursements, PO Box 823, Gainesville, FL. 32602-0823**