Please fax completed form to AvMed Claims Department: FAX: 1-305-671-6121

Dear Member:
Your **AvMed** contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. In order to expedite your claim(s) process, please complete the following information:

NOTE: If the reason for your medical care was not due to an accident related injury, do not complete Section I of the questionnaire. You should complete Section I and III only when applicable.

Patient Member ID Number _____
Patient Name _____
Provider Name _____
Date of Service _____

SECTION I
Is the reason for your visit to your doctor due to an injury caused by an accident?
Yes _____ No _____
If so, please indicate:
Auto _____ Home _____ School _____ Other _____
Date of Accident _____ How and where accident happened:
_____
_____

Was a third party responsible for the injury? Yes ____ No ____
If so, provide the following:
Name of individual or company: _____
Name and address of attorney representing third party insurance company or party responsible:
_____
_____

SECTION II
Full name of your spouse: _____
Spouse's Birth date: _____ Social Security Number: _____

Spouse's Employer: _____

Employer's Address: _____
_____ Telephone Number: _____
Is your spouse covered by any other Health Insurance Company: _____Yes _____No
If **YES**, give name, address and telephone number of Health Insurance Company:
_____
_____ Telephone Number: _____
Policy Number: _____ Effective Date: _____
Type of Coverage: _____ Family _____Couple _____ Single

Do you have Medicare coverage?
Part A ____ Effective Date _____ Part B ____ Effective Date _____

SECTION III (Information to be filled out only if auto accident)

Were you in your own or someone else's vehicle? _____
Name of your insurance company: _____
Amount of PIP coverage: _____ Amount of Deductible: _____
If represented by an attorney, please provide the following: Attorney name, address and telephone #:
_____
_____

Subscriber/Member Signature_____ Date _____

Revised 5/17/06