AvMed Embrace better health®

MENTAL HEALTH
Direct Member Reimbursement Form

Complete this form to request reimbursement for covered services.

Completion and submission of this form to AvMed is not a guarantee of reimbursement. Claims are subject to limitations, exclusions and other provisions of your Benefit Plan. Applicable reimbursement can only be made payable to the primary card holder only.

☐ **MEDICARE MEMBER** ☐ **COMMERCIAL MEMBER**

MEMBER INFORMATION (Submit a separate form for each family member)		
Member Name: (First, Last, Middle Initial)	Birth Date:	AvMed Member Number
Mailing Address:	Best Number to contact you at: Email:	
Provider's Name	Provider's Telephone Number:	Provider's Tax ID #:

REASON FOR MEDICAL REIMBURSEMENT

☐ Illness OR ☐ Injury? Date of Illness or Injury: Date of Service:

Description of illness or injury. Please include where injury occurred.

Member Signature:	Date Signed:

IMPORTANT CHECKLIST

To ensure timely processing, please review and complete this checklist prior to mailing your request.

- ☐ Form is completely filled out.
- ☐ Documents are in English, clear and legible. If not in English, please provide Translated records together with your form.
- ☐ Attach itemized bill from provider of service. This must include date of service, procedure codes for each service, charge amount for each service, diagnosis code, a description of the service performed, and the provider's contact information and Tax ID #.
- ☐ Attach proof of purchase; Sales receipt, canceled check, etc.
- ☐ Sign and Date form.

Mail this completed form and all documents to:

Optum
Attention: Member Reimbursement
P.O. Box 30760
Salt Lake City, UT 84130-0760

Please allow 30 business days for processing
Submitting the request directly to AvMed will delay the processing of the reimbursement