



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:
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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:
Magellan Healthcare
Attention: Member Reimbursement
P.O. Box 1777
Maryland Heights, MO 63043

Please allow 45 business days for processing