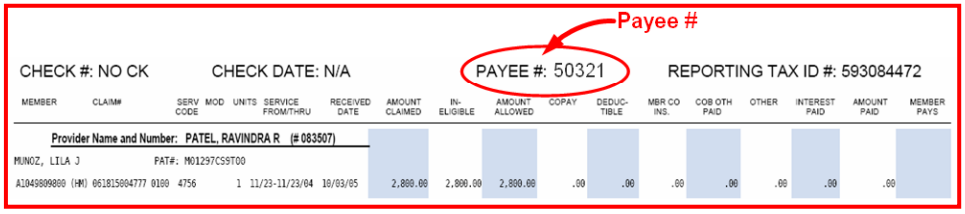
Please Sign & Fax or Mail To:
AvMed Health Plans
Provider Service Center
P.O. Box 569004
Miami, FL 33256-9942
Fax (305) 671-6149 or (877) 231-7695

Direct Deposit Authorization Form

AvMed will EFT (direct deposit) your claim payments DIRECTLY into your bank account!

We will also DELIVER your RA or EOP directly to your eMail Inbox as a PDF attachment!

"No Links, No Portals, No Downloads, No Kidding!"



PAYEE NAME (Legal Entity)	PAYEE NUMBER	TAX IDENTIFICATION NUMBER

EMAIL ADDRESS (Finance Dept Only)	PHONE NUMBER	CONTACT FIRST AND LAST NAME

A password reset PDF will be sent to the eMail above for you to create a "permanent" password that will secure your eMail delivered RA's or EOP's. Please allow up to 10 days for approval. Please check your Spam Filter/Folder for this eMail.

BANK NAME	NAME ON ACCOUNT	ROUTING NUMBER	ACCOUNT NUMBER

ATTACH A VOIDED CHECK
(Voided Check is Required)

Authorization is hereby given to AvMed Health Plans to credit said account at the financial institution named above for the purposes of transferring AvMed Health Plans payments. AvMed Health Plans is also granted authorization to correct funds erroneously deposited and other necessary debit/credit entries. This Authorization is to remain in effect until notification is given to AvMed Health Plans in writing (requires at least 10 days notice) on an AvMed Health Plans Direct Deposit Authorization Form advising of a change, allowing reasonable time to implement such changes.

If you have any questions, please call AvMed Provider Services Center at (800) 452-8633

AUTHORIZED SIGNATURE	PRINTED NAME AND TITLE	DATE

White copy – AvMed Yellow copy – Provider