Member Refund Form

AVON HMO

(For refunds of medical claims submitted by member)

LAST NAME	FIRST NAME	MIDDLE NAME	MEMBER BIRTH DATE

NAME OF COMPANY

MEMBER ID NO. STAFF ID NO.

TELEPHONE

ADDRESS

NAME & ADDRESS OF PROVIDER

DIAGNOSIS

REASON FOR REFUND

PLEASE INCLUDE THE FOLLOWING SUPPORTING DOCUMENTS IN ORDER TO PROCESS CLAIM

A) MEDICAL REPORT
B) ORIGINAL RECEIPT OF PAYMENT
C) OTHERS, PLEASE LIST

TOTAL AMOUNT CLAIMED CHEQUE PAYABLE TO

ENROLLEE AGREEMENT

I certify that all of the above information is accurate to the best of my knowledge; I agree to reimburse Avon HMO if a claim made to me is later found to be more than I was entitled to receive or that I am not entitled to a refund. (If this claim form is signed by the member's parent or legal guardian, these statements are agreed to by the signer on behalf of the enrollee).

(MEMBER'S OR LEGAL GUARDIAN'S SIGNATURE) DATE

FOR OFFICIAL USE ONLY

Did the enrollee/client contact Avon HMO within 48 hours of seeking care outside the network?

Confirmed by: Name: Signature:

Refund Approved? Yes: No: Reason:

Refund Amount Approved Reason for variation between amount claimed and amount approved

(If provider is in network and provided services are covered, shold refund be deducted from provider capitation?
Yes: No: If no, please give reason

Supporting document attached? Yes: No:

Investigated by

Name	Signature	Designation	Date

Approved by

Name	Signature	Designation	Date