Claim Filing Instructions & Claim Form

Claim Form & Authorization

In order for this form to be a valid proof of claim, you must attach the original documents and make certain that documentation is legible, indicate patient's name, date of service, diagnosis, procedure and/or type of service along with the itemized charges. Failure to submit an accurate, completed form will result in processing delays. The insured has a limited time frame in which to submit a complete proof of claim, and IMG, at its option, may deny coverage for proof of claim submitted thereafter, for incomplete proof of claim and/or failure to submit a proof of claim.

▶ **Mail to:**

International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA
Phone: 800.628.4664 or Outside U.S. +1.317.655.4500
Or via email to insurance@imglobal.com

*Overnight packages should be sent to:
2960 North Meridian Street,
Indianapolis, IN 46208

PART A. To be completed by the Claimant for all claims			
Claimant/Patient Name: (as it appears on ID card)		Government Issued ID Number:	
☐ Male ☐ Female		Date of Birth: *(month/day/year)*	
Claimant's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of Primary Insured: (as it appears on ID card)		Insured ID #:	
☐ Male ☐ Female		Date of Birth: *(month/day/year)*	
Home Country Address:		SSN/TIN:	
Current Address:		City:	
State:	Zip:	Home Phone:	Work Phone:
Communications should be sent via Email to:			
Are you in school full-time? ☐ Yes ☐ No		Group #:	
If yes, please provide name of school, address and phone number:			
Are you a U.S. citizen, permanent resident (i.e. green card), or required to file a U.S. tax return? ☐ Yes ☐ No			
How many months of the year are you residing in the U.S.?			
Alternate Payee Information			
Name:		SSN/TIN/EIN:	
Street Address:		Phone:	
City:	State:	Zip:	Country:
Email:			

If Claimant is or may be covered by other coverage, complete items below

Name of Primary Insured: (as it appears on ID card)			Date of Birth: *(month/day/year)*
Insured Mailing address:	City:	State:	Postal Code:
Name of other carrier:	ID # for other coverage:		
Type of other coverage:	Carrier Phone number:		
Carrier address:	City:	State:	Postal Code:
Name of employer:	Employer Phone number:		
Employer address:	City:	State:	Postal Code:

PART B. To be completed by the Claimant for each new condition, injury or illness (if you need additional space, please attach a separate sheet)

1. When did the first symptom of this condition begin? State the exact date if possible. (*month/day/year*)

2. How did the condition begin? State fully all symptoms and describe the condition in detail after it began. For accidents, include pertinent details such as how, when and where the accident occurred.

3. Have you ever had or been treated for this type of condition before? ☐ Yes ☐ No

4. List all the names and addresses of the providers you have seen for this condition.

5. What sickness, diseases, illnesses, injuries, or other physical, medical, mental or nervous disorder, conditions or ailments have you experienced during the last five years?
Please provide the name and/or description of each condition, dates of treatment, and name and address of the facility and/or attending physician(s).

6. Is this condition the result of an accident, injury, or illness:

   a. Related to employment? ☐ Yes ☐ No
   If yes, are you applying for Worker's Compensation benefits? ☐ Yes ☐ No

   b. Involving a motor vehicle or another person's actions? ☐ Yes ☐ No
   If yes, list the names of parties involved, insurance carriers and policy numbers.

   c. Was a report filed with any governmental or investigating entities? ☐ Yes ☐ No
   If yes, please identify the department and the address where it was filed.

PART C. Complete for all treatment received outside of the United States

Date of service *(month/day/year)*	Provider	What type of service and/or name of drug provided?	What was the illness/injury?	City/ country	Type of currency paid or billed	Total charge paid or billed	Converted to US funds	Office use only

PART D. Payment Details

☐ Make payment to the provider	If payment is to be paid to the provider, please ensure bank information is on the provider invoice		
☐ Make payment to Primary Insured	Reimbursement Method	☐ U.S. Dollar Check	☐ Bank Wire Transfer (complete below)
☐ Make payment to Alternate Payee	Reimbursement Method	☐ U.S. Dollar Check	☐ Bank Wire Transfer (complete below)

When possible, utilizing U.S. bank accounts is recommended to avoid unnecessary fees by the receiving bank. U.S. bank accounts (only) wires will be completed via ACH which generally eliminates or reduces wire transaction fees.

Account Holder's Name - Must be: Principal Member (Policyholder)		
Bank Name:		
Bank Address:	City:	Country:
Currency of Reimbursement:	Bank 9 digit ABA Number - U.S. Banks:	
Bank 8 or 11 digit SWIFT Code - Non- U.S. Banks:	SORT code:	
Bank account number:	Bank IBAN:	
Intermediary Bank Details *(If Applicable)*		
Name of Intermediary Bank:		
Intermediary Bank SWIFT Code:	Intermediary Bank Account Number:	

PART E. Authorization - to be completed by the Claimant *for all claims.*

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has any records or knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications, and any other information concerning me and to give any and all such information to my agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted.

I understand that I have the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. I acknowledge and understand there is the potential for the information to be subject to re-disclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Insured:_____

Signature of Insured/Legal Representative1:_____Date:_____ *(month/day/year)*

AUTHORIZATION: I authorize payment of any benefits for eligible medical expenses to the provider or other supplier of services which is entitled to payment of the attached bills.

Signature of the Insured/Legal Representative :_____Date:_____*(month/day/year)*

PART F. Privacy and Confidentiality Release Form

By completing this form, you are providing your consent for IMG to discuss information regarding your claim with the person(s) listed below. Without this written authorization, applicable laws do not permit IMG to discuss information protected under confidentiality and privacy laws with anyone other than your physician(s) or provider(s) of service.

I authorize IMG to discuss my claim with _____who is_____

This authorization is valid for _____ months from the date signed (maximum of 12 months).

I give IMG permission to release the following information:

(Please select and initial)

☐_____Financial and claim information related to medical bills or claim form.

☐_____Provider name, date of service, total charge, total amount paid and date of payment.

☐_____Insurance ID number and/or patient account number

Privacy and confidentiality laws do not permit the release or re-disclosure of medical records obtained from a medical provider. Your medical information and records can be obtained directly from your medical provider.

I have read the contents of this form. I understand, agree, and allow IMG to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand IMG does not require that I sign this form in order for me to receive treatment, payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to IMG. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Print Patient Name:_____ Insurance ID Number:_____

Signature of the Patient or parent if the patient is a minor child: _____

Date:_____ *(month/day/year)*

If this form is signed by someone other than the patient or parent, such as a personal representative, legal representative or guardian on behalf of the patient, submit the following: a copy of a health care representative form, power of attorney, a court order or other documentation showing custody, or other legal documentation showing the authority of the legal representative to act on the patient's behalf.