Claim Form & Authorization Filing Instructions

For improved user experience, communication, and efficiency, we recommend you submit your claim online via MyIMG. While most IMG products are available for online claims submissions, please continue to use this form for all other products

> If using this form, please print legibly and complete ALL SECTIONS of this form. Mail, fax, or submit the completed form online:
> **Address:** International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
> **Call:** +1.800.628.4664 or outside U.S. +1.317.655.4500; **Fax:** +1.317.655.4505

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, indicates 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 (the "Company"), 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.

PART A. To be completed by the claimant for all claims			
Claimant/Patient Name: (As it appears on ID card)		Passport/Visa Number:	
☐ Male ☐ Female		Date of Birth: *(MM/ DD/YYYY)*	
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: *(MM/ DD/YYYY)*	
Home Country Address:			
Current Address:			City:
State:	Postal Code:	Home Phone:	Work Phone:
Communications should be sent via email to:			
Are you a full-time student? ☐ Yes ☐ No		Group #:	
If yes, please provide the following information:			
Name of School:			
Street Address:			Phone:
City:	State:	Postal Code:	Country:
Email:			
How many months of the year are you residing in the U.S.?			

ALTERNATE PAYEE INFORMATION			
Name:			
Street Address:			Phone:
City:	State:	Postal Code:	Country:
Email:			

If claimant is or may be covered by other coverage, complete the items below.			
Name of Primary Insured: *(as it appears on ID card)*			Date of Birth: *(MM/ DD/YYYY)*
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: *(MM/ DD/YYYY)*

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 sicknesses, 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.

   d. Was this accident related to an organized or sanctioned athletic activity, ☐ Yes ☐ No
   involving regular or scheduled games and/or practice? If so, was an accident report filed with the sports coordinator? Please provide a copy of any related accident reports.

   e. In the event you have hired legal counsel, please provide IMG with the complete name, address and telephone number of the attorney.

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

Date of service *(MM/ DD/YYYY)*	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 U.S. funds	Office use only

PART D. PAYMENT DETAILS (Checks will only be issued to a United States address.)

☐ Make payment to the provider			
☐ Make payment to primary insured	Reimbursement method	☐ Bank ACH or wire transfer (complete below)	☐ Check
☐ Make payment to alternate payee	Reimbursement method	☐ Bank ACH or wire transfer (complete below)	☐ Check

Account Holder's Name:		
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 Representative: X_____ Date: *(MM/ DD/YYYY)*

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: X_____ Date: *(MM/ DD/YYYY)*

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 healthcare 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.

If needed you can overnight packages to following address:
International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA