

GEOSM Group Claim FormMust be submitted to International Medical Group[®] within 180 days of date of service.

PART A. Claim	iant/Patient i			ed and sign	ed by the Clai	mant for all	claims.		
Claimant/Patie	ent Name:	(Surname, Fi	rst, Initial)						
☐ Male	☐ Female			day / mo / yr Date of Birth:					
		Primary Insured	I Self			Child	☐ Other		
(as appears on ID card) Name of Primary Insured:									
		- ·		day / mo / yr					
☐ Male ☐ Female Date of Birth: Claims Correspondence Address:									
	·		Makila Di	Mobile Phone: Email:					
Home Phone: (as appears on ID card)							appears on ID card)		
Group # :				a bolow	ID # :	(=== ==			
If Claimant is o		(as appears o		S Delow.				day / mo/ yr	
Name of Prima	•							Date of Birth:	
Group name or # of other plan: Policy # of other plan:									
Name of other carrier:									
Carrier addres	SS:	T	Otata/D			Γ	Deatal Carley		
City:			State/Proven	tate/Provence: Postal Code:					
Country: PART B. Claims Information									
How did illness/condition occur: day / mo/ yr Date occurred:									
Where did it occur:									
If injury, did it occur while working? ☐ Yes ☐ No									
If injury, was it due to an auto accident?									
Have you ever been treated for this illness/condition before? Yes No If yes, please provide details, name and address of the treating physician along with date(s) of the treatment.									
PART C. Complete for all treatment received where insured has paid and requests reimbursement.									
Date of service dd/mm/yr	Provider	What type of service was provided?	What was the condition/ injury?	City/ Country	Type of currency paid or billed	Total charge paid or billed	Converted to U.S. funds	Office use only	

PART D. Claims Reimbursement- Alternate Payee Request- Must be com An alternate payee may be elected to receive payment by draft (in USD only) provider of medical service(s).						
Print name of requested alternate payee:						
Print mailing address for alternate payee draft, if requesting a different location than the insured:						
Wire Transfer Request- If payment is to be sent by wire transfer, please nformation (Wire cannot be honored if below is incomplete or inaccurate. If no cu						
Name of account holder (how it appears on account):						
Bank Account (U.S.) or IBAN (non-U.S.):						
Sort or Swift Code (non-U.S. Bank):						
Routing Number (U.S. bank):						
Requested currency for transfer:						
Bank name:						
Bank phone number:						
Bank address:						
PART E. Authorization – To be completed by the Claimant for all cl						
verify that all information contained in this form is true, correct, and complete to the best of my knowledge. authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to International Medical Group [®] , Inc. or any agent or administrator acting on its behalf.						
understand that I have the right to receive a copy of this authorization upriginal. This authorization is valid for twelve months from the date signer						
Print Name						
Signature of Insured/ Guardian	Date day/ mo/ yr					
AUTHORIZATION: I authorize payment of medical benefits to the docto the attached bills.	r or other supplier of services submitting					
Signature of the Insured/ Guardian	Date day/ mo/ yr					
Form IMG- 37	Updated 11/06					

Forward Claims to:

International Medical Group[®], Inc.

P.O. Box 88500 Indianapolis, IN 46208-0500 Outside U.S. & Canada: 317.655.4500 Inside U.S. & Canada: 800.628.4664 Fax: 317.655.4505

OR

IMG Europe Ltd.

36-38 Church Road, Burgess Hill West Sussex, RH15 9AE United Kingdom Phone: +44 (0) 1444 46 55 55

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