

International Educators Claim Form



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

Please print legibly and complete ALL SECTIONS of this form. Mail, fax, or email completed form to: **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
Web: www.imglobal.com/secure-message-center www.imglobal.com

PART A.

Who is this Claimant? Primary Insured Dependent

PRIMARY INSURED INFORMATION

Name: Male Female Married Single

Date of Birth: ___/___/___ (MM/DD/YYYY)

Address:

Phone:

Email:

Fax:

Policy#:

Name of Employer:

DEPENDENT INFORMATION

Male Female Spouse Child

Date of Birth: ___/___/___ (MM/DD/YYYY)

Address:

Phone:

Email:

Fax:

Relationship to insured:

Date dependent insurance began: ___/___/___ (MM/DD/YYYY)

PART B. Describe Injury or Illness

Where injury / illness occurred:

Date occurred: ___/___/___ (MM/DD/YYYY)

If injury, how it occurred:

Did injury occur while working? Yes No

Is injury due to an auto accident? Yes No

Are you covered by other insurance? Yes No

Policy #:

Name of other insurance company:

PART C. PAYMENT INFORMATION Please furnish an address for an Explanation of Benefits (EOB) and/or a reimbursement.

Address to send funds/EOB:

Electronic Transfer Information:

Name of Bank:

Name of Bank account holder:

Bank location/ address:

Bank account number:

Bank ID# or ABA/ Swift number:

ALTERNATE PAYEE INFORMATION

Name:

Street Address:

Phone:

City:

State:

Postal Code:

Country:

Email:

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

<input type="checkbox"/> Make payment to the provider			
<input type="checkbox"/> Make payment to primary insured	Reimbursement method	<input type="checkbox"/> Bank ACH or wire transfer (complete below)	<input type="checkbox"/> Check
<input type="checkbox"/> Make payment to alternate payee	Reimbursement method	<input type="checkbox"/> Bank ACH or wire transfer (complete below)	<input type="checkbox"/> 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. Complete for all treatment received outside of the United States.

Date of service <small>(MM/DD/YYYY)</small>	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 F. 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 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.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed.

Print Name of Insured: _____	ID #:
Signature of Insured/Guardian: 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 Insured/Guardian: X _____	Date: __/__/__ (MM/DD/YYYY)
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