International Educators Claim Form

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 9162, Farmington Hills, MI 48333-9162 USA,
Call: +1.800.628.4664 or outside U.S. +1.317.655.4500; **Fax:** +1.317.655.4505
Email: customercare@imglobal.com
www.imglobal.com

PART A.

Who is this Claimant? ☐ Primary Insured ☐ Dependent

PRIMARY INSURED INFORMATION	DEPENDENT INFORMATION
Name:	☐ Male ☐ Female ☐ Spouse ☐ Child
☐ Male ☐ Female ☐ Married ☐ Single	Date of Birth: ___/___/___ (MM/ DD/YYYY)
Date of Birth: ___/___/___ (MM/ DD/YYYY)	Address:
Address:	
	Phone:
Phone:	Email:
Email:	Fax:
Fax:	Relationship to insured:
Policy#:	Date dependent insurance began: ___/___/___ (MM/ DD/YYYY)
Name of Employer:	

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.)

☐ 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. 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 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)*

If needed you can overnight packages to following address:
2960 North Meridian Street, Indianapolis, IN 46208