MP+ International Claim Form & Authorization Filing Instructions

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
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

Please follow these instructions prior to filing a claim and when completing the claim form. Assistance is also available from the International Medical Group® (IMG®) Customer Service Department at the telephone numbers listed above.

IF YOU HAVE NOT YET RECEIVED TREATMENT:

Precertification (notification of illness or accident):
You must call IMG to precertify any of the following conditions: any treatment requiring hospitalization; outpatient surgery, CAT scans, within 48 hours after an emergency admission to the hospital; care in an extended care facility; home nursing care; durable medical equipment including artificial limbs; or transplants. Precertification may be done by you, a relative, or a hospital representative.

Independent Preferred Provider Organization (PPO): Your plan may recommend you receive treatment from a provider within the US PPO. You may access a listing of physicians or facilities by:

- Using the IMG website, www.imglobal.com. This provides a complete listing of providers by specialty and geographic location.
- Contact the IMG Customer Service Department at the telephone number or mailing address listed below for a list of providers in your area. Please note, due to the size of the PPO network we can only send directories for your immediate area.

When receiving treatment from a PPO provider, please follow these instructions:

- Present your IMG medical identification card to the provider.
- Request that the provider send the bill directly to IMG. Please note, if you pay directly to the provider for an eligible expense this will likely affect your reimbursement from IMG. The negotiated fee for services will be the maximum reimbursement, whether paid to the provider or to you.
- Complete the Claim Form and submit it with all bills or invoices. If the provider has filed the claims on your behalf, simply forward the completed Claim Form to IMG.
- When receiving treatment from a PPO provider for eligible expenses, the submitted bills must be re-priced through the PPO to the negotiated rate. This procedure may extend the normal processing time of your claim.

IF YOU HAVE ALREADY RECEIVED TREATMENT:

- If this is a new claim, complete ALL PARTS of the Claim Form. If treatment was received in the United States you do not need to complete PART C.
- If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all itemized bills, statements and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

Our goal at IMG is to process your claim quickly, accurately and efficiently. In order to achieve this, the Claim Form must be fully and accurately completed. Failure to do this will result in processing delays.

DIRECTIONS FOR SUBMITTING A CLAIM: There are four parts to this form—A, B, C, & D. Please carefully review the instructions below.

- If this a new claim, complete ALL PARTS of this form. If treatment was received in the United States you do not need to complete PART C.
- If this is a continuing claim, complete PARTS A & D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all itemized bills, statements, and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis, and the itemized charges.

Notice: *Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.*

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	
If yes, please provide name of school, address and phone number:	
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 items below

Name of Primary Insured: (As it appears on ID card)			Date of Birth: ___/___/___ (MM/DD/YYYY)
Group # of other plan:	ID # for other coverage:		
Insured mailing address:	City:	State:	Postal Code:
Name of other carrier:	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 D. 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)*

PART E. 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 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: 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 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.

If needed you can overnight packages to following address:
PO Box 240429, Apple Valley, MN 55124