MP+International®
Claim Filing Instructions & Claim Form

INTERNATIONAL MEDICAL GROUP

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 below.

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 U.S. 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.

Mail the completed form to:
International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA

For additional assistance:
Phone: 1.800.628.4664 (In U.S.) 1.317.655.4500 (Outside U.S.)
Fax: 1.317.655.4505
E-mail: customercare@imglobal.com Web: www.imglobal.com

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.

Claim Form & Authorization

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 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.

Mail to: **International Medical Group, Inc.**
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA
Phone: 1.800.628.4664 or Outside U.S. 1.317.655.4500

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 and signed by the Claimant for all claims.

Claimant/Patient Name: (as appears on ID card)		
☐ Male ☐ Female	Date of Birth: mo /day /yr	
Claimant's Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Primary Insured: (as appears on ID card)		
☐ Male ☐Female	Date of Birth: mo /day /yr	
Home Country Address:		
Current Address:		
Home Phone:	Work Phone:	E-mail:
Group # :	ID # :	
Are you in school full-time? ☐ Yes ☐ No		
If yes, please provide name of school and the address:		
Are you a U.S. Citizen? ☐ Yes ☐ No		
How many months of the year are you in the U.S.?		

If Claimant is covered by another plan, complete items below.

Name of Primary Insured: (as appears on ID card)		Date of Birth: mo /day/yr
Group # of other plan :	ID # of other plan :	
Mailing address	Name of other carrier	
City	Carrier address	
State	Postal Code	City
Name of employer	State	Postal Code

PART B. To be completed by the Claimant for new claims only. (If you need additional space, please attach a separate sheet.)

1. **How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning. For accidents, include how, when and where the accident occurred.**

2. **When did the first symptom of this condition begin? State the exact date if possible.** mo / day / yr

3. **Have you ever had or been treated for this type of injury or illness before?** ☐ Yes ☐ No

4. **List all the names and addresses of the providers you have seen for this condition.**

5. **What ailments, diseases, illnesses or injuries have you experienced during the last five years? Please provide the name and/or description of each condition, dates and name and address of the attending physician(s).**

6. **Is this condition the result of an accident 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? ☐ Yes ☐ No
   If yes, please list the names of involved parties, insurance carriers and policy numbers.

   c. Was a police report filed? ☐ Yes ☐ No
   If yes, please identify the Police Department where it was filed.

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

Date of service *mm/dd/yr*	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 US funds	Office use only

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 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_____

Signature of Insured/Guardian_____ Date_____

AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of the Insured/Guardian_____ Date_____

PRIVACY AND CONFIDENTIALITY RELEASE FORM

By completing this form, you are providing your consent to IMG® to discuss your claim activity with the person(s) listed below. Without this release form, IMG cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service.

I authorize IMG to discuss my claim activity with _____.
This authorization is valid for_____months from the date signed.

I give IMG permission to release any or all of the following information:

(Please select and initial)

☐ _____ All financial and claim information related to medical bills or Claimant's Statement and Authorization.

☐ _____ Provider name, date of service, total charge, total paid and date of payment.

☐ _____ Insurance ID number and/or social security number.

Under no circumstances can IMG release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law for further disclosure. Please contact your physician or provider of service for your medical information.

_____ _____
Print Patient Name Insurance ID Number

_____
Signature of the Patient or Insured Person if the patient is a minor child

_____
Date

Please provide your current mailing address:

Street Address	
City	State, Country, Postal Code

Mail or fax to: **Claims Department**
International Medical Group
P.O. Box 88500
Indianapolis, IN 46208-0500
Telephone: 1.317.655.4500
Fax: 1.317.655.4505