GEO[SM] Group Claim Form

Must be submitted to International Medical Group® within 180 days of date of service.

INTERNATIONAL MEDICAL GROUP

PART A. Claimant/Patient information - To be completed and signed by the Claimant for all claims.

(Surname, First, Initial) Claimant/Patient Name:		
☐ Male ☐ Female	Date of Birth: day / mo / yr	
Claimant's Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
(as appears on ID card) Name of Primary Insured:		
☐ Male ☐ Female	Date of Birth: day / mo / yr	
Claims Correspondence Address:		
Home Phone:	Mobile Phone:	Email:
(as appears on ID card) Group # :	(as appears on ID card) ID # :	

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

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

PART B. Claims Information

How did illness/condition occur:	Date occurred: day / mo/ yr
Where did it occur:	
If injury, did it occur while working? ☐ Yes ☐ No	
If injury, was it due to an auto accident? ☐ Yes ☐ No	
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 completed by Parent or Guardian if insured is under 18 years of age. An alternate payee may be elected to receive payment by draft (in USD only), when requested payment is to someone other than insured or 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 indicate below by completing full details of bank and/or transfer information (Wire cannot be honored if below is incomplete or inaccurate. If no currency is requested, claims will be settled in USD)

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 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 _____
day/ mo/ yr

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 _____
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

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