GlobeHopper℠ Senior Claim Form Help Sheet

International Medical Group®, Inc. (IMG®) reserves the right to request further information to support your claims.

FIELD #	FIELD NAME	DESCRIPTION
1.	Insured's ID #	Number found on front of IMG ID card
2.	Insured's Date of Birth/Gender	Month (2 digits), Day (2 digits), Year (4 digits) M = Male, F = Female
3.	Insured's Name	Surname, given name, and middle initial
4.	Insured's Address	Address for claims information and Explanation of Benefits
5.	Medicare ID#	Number listed on Medicare card
6.	Medicare Plan Type	Select Medicare Plan number(s) enrolled under ☐ A – Hospital ☐ B – Medical ☐ C – Advantage ☐ D – Rx drugs
7.	Medigap Plan	Select Medigap plan type (Should be on the front of the ID card) ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **F** ☐ **G** ☐ **K** ☐ **L** ☐ **M** ☐ **N**
8.	Medicare Advantage or Medigap Policy # and Insurance Information	Name of insurance carrier and contact information
9.	Diagnosis	Detailed description of illness or injury
10.	Treatment Information	The date(s) the services were provided to the Insured and the name and address of the provider. Detailed description of procedures, services, or supplies provided, and currency and amount paid for services
11.	Proof of Service(s)	An itemized listing of services and payment from the practitioner or facility
12.	Proof of Payment	Documentation that validates and proves your payment
13.	Signature of Insured	Form must be signed by insured

GlobeHopper℠ Senior 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

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Please print clearly, complete all sections, and sign. Retain a copy of all receipts and documents for your records.

1. Insured's ID:	Gender: ☐ Male ☐ Female	**2.** Date of Birth: ___/___/___ *(MM/DD/YYYY)*	
3. Insured's Name:	Last:	First:	Middle Initial:
4. Insured's Address:			
Street Address:			
City:	State/Province:	Postal Code:	Country:
Email Address:			
5. Medicare ID Number:		**8.** Medicare Advantage or Medigap Policy:	
6. Medicare Plan Type: Select Medicare Plan Type(s) Enrolled Under: ☐ **A.** Hospital ☐ **C.** Medicare Advantage ☐ **B.** Medical ☐ **D.** Rx Drugs		Policy Number: Insurance Carrier:	
7. Medigap Plan: Select Medigap Plan Type: ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **F** ☐ **G** ☐ **K** ☐ **L** ☐ **M** ☐ **N**		Address: City/State/Postal Code:	
9. Diagnosis: What were you seen for? *(e.g. flu, broken leg, cold, etc.)* Detailed Description of Illness or Injury:			
10. Provide Proof of Services with the following:			

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

11. Provide Proof of Services with the following:

☐ An itemized bill from the provider of service, listing dates of service, services provided, and dollar amounts paid.

ALTERNATE PAYEE INFORMATION

Name:			
Street Address:		Phone:	
City:	State:	Postal Code:	Country:
Email:			

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:		

12. Proof of payment through one of the following (*check which method applies*):

☐ Receipt of payment by provider for cash payments. Cash payments must also include proof for source of funds *(e.g. Wire Transfer, Travelers Check, Check Receipt, Credit Card Statement, Bank Statement)*

☐ Financial statement to include a copy of front and back of canceled check made out to the provider

☐ Credit card statement including service receipt

13. I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Form must be signed. Claim cannot be processed without member's signature.

Signature of Insured: **X**_____	Date: ___/___/___ *(MM/DD/YYYY)*
Signature of Subscriber, if insured is a minor: **X**_____	Date: ___/___/___ *(MM/DD/YYYY)*