# Claimant's Statement and Authorization Form

Must be submitted to International Medical Group®, Inc. (IMG®) within 90 days of date of service.

## DIRECTIONS FOR SUBMITTING A CLAIM

» If this is a new claim, complete ALL PARTS of this form.
» If this is a continuing claim, complete PARTS A AND C.
» Attach all original itemized bills, statements and invoices for services and supplies.
» Please make certain that all documents indicate claimant's name, date of service, diagnosis and that itemized charges.
» Mail to: International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA
Phone: 800.628.4664 or Outside US 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. Claimant/Patient information - To be completed and signed by the Claimant for all claims. | | |
|---|---|---|
| CLAIMANT/PATIENT NAME: (SURNAME, FIRST, INITIAL) | | |
| ☐ MALE ☐ FEMALE | | DATE OF BIRTH: (DD/MM/YYYY) |
| CLAIMS CORRESPONDENCE ADDRESS: | | |
| HOME PHONE: | MOBILE PHONE: | EMAIL: |
| CERTIFICATE #: (AS APPEARS ON ID CARD) | | INSURED'S A #: (AS APPEARS ON ID CARD) |

| If Claimant is covered by another plan, or eligible for SSI or Medicare, complete items below. | | |
|---|---|---|
| NAME OF PRIMARY INSURED: (AS APPEARS ON ID CARD) | | DATE OF BIRTH: (DD/MM/YYYY) |
| 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 - To be completed by Insured for new claims only (if you need additional space, please attach a separate sheet).

| | |
|---|---|
| HOW DID THE CONDITION BEGIN? STATE FULLY ALL SYMPTOMS AND DESCRIBE THE CONDITION IN DETAIL FROM THE BEGINNING. FOR ACCIDENT, INCLUDE HOW, WHEN AND WHERE. | |
| WHEN DID THE FIRST SYMPTOM OF THIS CONDITION BEGIN? STATE EXACT DATE IF POSSIBLE. | |
| IS THIS CONDITION THE RESULT OF AN ACCIDENT OR ILLNESS? ☐ YES ☐ NO | |
| RELATED TO EMPLOYMENT? ☐ YES ☐ NO | IF YES, ARE YOU APPLYING FOR WORKERS COMPENSATION BENEFITS? ☐ YES ☐ NO |
| INVOLVING A MOTOR VEHICLE? ☐ YES ☐ NO | IF YES, PLEASE LIST NAMES OF INVOLVED PARTIES, INSURANCE CARRIERS AND POLICY NUMBERS. |
| WAS A POLICE REPORT FILED? ☐ YES ☐ NO | IF YES, PLEASE ATTACH A COPY OF REPORT. |
| HAVE YOU CONTACTED AN ATTORNEY? ☐ YES ☐ NO | IF YES, PLEASE PROVIDE NAME, ADDRESS AND TELEPHONE NUMBER. |

## PART C. 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 ______________
dd/mm/yyyy

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

Signature of Insured/Guardian ______________________________ Date ______________
dd/mm/yyyy