Vision
Reimbursement 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

DIRECTIONS FOR SUBMITTING A CLAIM

- Complete *ALL PARTS* of the Claim Form. If treatment was received in the United States you do not need to complete PART 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 the itemized charges.

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)		Group Name:	
☐ 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 the following information:			
Name of School:			
Street Address:			Phone:
City:	State:	Postal Code:	Country:
Email:			
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:			

PART B. 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 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. 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 of Insured: _____	ID #:
Signature of Insured/Guardian: 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 Insured/Guardian: X_____	Date: ___/___/___ *(MM/ DD/YYYY)*