# Dental Claim Filing Instructions & 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

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 above.

## DIRECTIONS FOR REQUESTING A PREDETERMINATION OF BENEFITS:

To save yourself from costly coinsurance and charges for expenses which are not covered, you should have your dentist submit a Predetermination of Benefits. If charges for a course of dental treatment are expected to equal or exceed $500, have your dentist complete a pre-treatment claim form and send it to us along with his treatment plan. We will review the treatment plan and tell you and your dentist how much will be paid by IMG and how much will be paid by the patient.

## DIRECTIONS FOR SUBMITTING A CLAIM: (There are four parts to this form—A, B, C & D. Please carefully review the instructions below.)

- 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.

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.

**Notice:** Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.

# Dental Claim Form & Authorization

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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
**Email:** customercare@imglobal.com
www.imglobal.com

## **PART A.** To be completed by the claimant for all claims

| | | | |
|---|---|---|---|
| Claimant/Patient Name:<br>(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:<br>(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.? | | | |

## Do you have other health insurance? If Yes, please compete the section below.

| | | | |
|---|---|---|---|
| Name of Primary Insured: *(as it appears on ID card)* | | | Date of Birth: ___/___/___ *(MM/ DD/YYYY)* |
| Insured mailing address: | City: | State: | Postal Code: |
| Name of other carrier: | ID # for other coverage: | | |
| Type of other coverage: | Carrier Phone number: | | |
| Carrier address: | City: | State: | Postal Code: |
| Name of employer: | Employer Phone number: | | |
| Employer address: | City: | State: | Postal Code: |

## PART B. *(If you need additional space, please attach a separate sheet.)*

1. **Is this condition the result of an accident?** ☐ Yes ☐ No

   If yes,

   A. Provide details of the accident such as,
   - What were you doing when you were injured?
   - Explain your injuries

   B. Is this condition related to employment? ☐ Yes ☐ No

   If yes, are you applying for Worker's Compensation benefits? ☐ Yes ☐ No

   C. Did this accident or injury involve a motor vehicle? ☐ Yes ☐ No

   If yes, please list the names of involved parties, insurance carriers, and policy numbers

   D. Was a police report filed? ☐ Yes ☐ No

   If yes, please identify the Police Department where it was filed.

2. **Had these teeth previously been repaired?** ☐ Yes ☐ No

   If yes, please list which ones, what was done, and date repaired. ___/___/___ *(MM/ DD/YYYY)*

3. **Are there any claims attached for orthodontics (braces)?** ☐ Yes ☐ No

   If yes, please provide the initial placement date. ___/___/___ *(MM/ DD/YYYY)*

4. **Are any of these services for teeth that have been previously extracted?** ☐ Yes ☐ No

   If yes, please provide the date of extraction and what tooth (teeth) were extracted.

**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 |
|---|---|---|---|---|---|---|---|---|
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## ALTERNATE PAYEE INFORMATION

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

## PART D. 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 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 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)* |

## **PART F.** 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 with _____ who is _____

This authorization is valid for _____ months from the date signed (maximum of 12 months).

| | | |
|---|---|---|
| I give IMG permission to release the following information: *(Please select and initial)* | ☐ | _____ Financial and claim information related to medical bills or claim form. |
| | ☐ | _____ Provider name, date of service, total charge, total amount 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 #: |
| Signature of the Patient or parent if the patient is a minor child: X_____ | Date: ___/___/___ *(MM/ DD/YYYY)* |

## PLEASE PROVIDE YOUR CURRENT MAILING ADDRESS:

| | | | |
|---|---|---|---|
| Street Address: | | | |
| City: | State: | City: | Country: |
| Postal Code: | | | |