

Dental Reimbursement Form



To submit a claim:

1. Complete ALL parts of this form.
2. Attach all original itemized bills, statements and invoices for services and supplies. Please verify that all documents indicate your name, date of service, diagnosis, and the charge for each service.
3. Mail to:

Claims Department
 International Medical Group
 407 Fulton Street
 Indianapolis, IN 46202 USA

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

Part A. Must be completed and signed by the insured for all claims.

Insured Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Patient Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Home Country Address		
Home Phone:	Work Phone:	Email:
Group #:	ID#	
Are you in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the school and the address:		
Do you have other dental coverage which might cover dental expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:		
Company Name	Phone Number	
Policyholder Name	Policy Number	

Part B. Must be completed by the insured person 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 _____ Date _____