Dental Claim Filing Instructions & Claim Form

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 below.

DIRECTIONS FOR REQUESTING A PRE-DETERMINATION OF BENEFITS:

To save yourself from costly coinsurance and charges for expenses which are not covered, you should have your dentist submit a Pre-Determination 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.

Mail the completed form to:
International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA

For additional assistance:
Phone: 1-800-628-4664 (In US) 1-317-655-4500 (Outside US)
Fax: 1-317-655-4505
Email: insurance@imglobal.com **Web: www.imglobal.com**

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

DIRECTIONS FOR SUBMITTING A CLAIM

- Complete ALL PARTS of this 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.
- **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
  Email: insurance@imglobal.com Web: www.imglobal.com

PART A. To be completed and signed by the Claimant for all claims.

Claimant/Patient Name: (as appears on ID card)		Group Name:
☐ Male ☐ Female	Date of Birth: mo /day /yr	
Claimant's Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Primary Insured: (as appears on ID card)		
☐ Male ☐ Female	Date of Birth: mo /day /yr	
Home Country Address:		
Current Address:		
Home Phone:	Work Phone:	E-mail:
Group # :	ID # :	
Are you in school full-time? ☐ Yes ☐ No		
If yes, please provide name of school and the address:		
Are you a U.S. Citizen? ☐ Yes ☐ No		
How many months of the year are you in the U.S.?		

If Claimant is covered by another dental plan, complete items below.

Name of Primary Insured: (as appears on ID card)		Date of Birth: mo /day/yr	
Group # of other plan :	ID # of other plan :		
Mailing address		Name of other carrier	
City		Carrier address	
State	Postal Code	City	
Name of employer		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.

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

If yes, please provide the initial placement date.

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. For all treatment received outside of the United States, complete Part C.

Date of service *mm/dd/yr*	Provider	What type of service provided?	Reason service received	City/ country	Type of currency paid or billed	Total charge paid or billed	Converted to US 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_____ Date_____

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

Signature of the Insured/Guardian_____ Date_____

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 activity with _____.
This authorization is valid for_____months from the date signed.

I give IMG permission to release any or all of the following information:

(Please select and initial)

☐ _____ All financial and claim information related to medical bills or Claimant's Statement and Authorization.

☐ _____ Provider name, date of service, total charge, total 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 Number

_____
Signature of the Patient or Insured Person if the patient is a minor child

_____
Date

Please provide your current mailing address:

Street Address	
City	State, Country, Postal Code

Mail or fax to: **Claims Department**
International Medical Group
P.O. Box 88500
Indianapolis, IN 46208-0500
Telephone: 317-655-4500
Fax: 317-655-4505
Email: insurance@imglobal.com
Web: www.imglobal.com