GlobeHopper℠ Senior - Claim Form

(One patient per provider)

International Medical Group®, Inc. (IMG®) reserves the right to request further information to support your claims.

Please print clearly, complete all sections and sign. Retain a copy of all receipts and documents for your records.

1. INSURED ID: GENDER: ☐ MALE ☐ FEMALE

2. DATE OF BIRTH (MM/DD/YYYY): _____/_____/_____

3. INSURED NAME: LAST FIRST MIDDLE INITIAL

4. INSURED ADDRESS:

STREET ADDRESS

CITY STATE/PROVINCE ZIP/POSTAL CODE COUNTRY

EMAIL ADDRESS: _____

5. MEDICARE ID NUMBER:

6. MEDICARE PLAN TYPE: CIRCLE MEDICARE PLAN TYPE(S) ENROLLED UNDER.

A. HOSPITAL C. MEDICARE ADVANTAGE
B. MEDICAL D. RX DRUGS

7. MEDIGAP PLAN: CIRCLE MEDIGAP PLAN TYPE:

A B C D F G K L M N

8. MEDICARE ADVANTAGE OR MEDIGAP POLICY:

POLICY NUMBER: _____

INSURANCE CARRIER: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

9. DIAGNOSIS: WHAT WERE YOU SEEN FOR? (E.G. FLU, BROKEN LEG, COLD, ETC.)

DETAILED DESCRIPTION OF ILLNESS OR INJURY: _____

10. TREATMENT INFORMATION: COMPLETE FOR ALL TREATMENT RECEIVED OUTSIDE OF THE UNITED STATES.

DATE OF SERVICE MM/DD/YYYY	PROVIDER NAME AND ADDRESS	CITY/COUNTRY	WHAT WAS THE ILLNESS/INJURY	WHAT TYPE OF SERVICE AND/OR NAME OF DRUG PROVIDED?	TYPE OF CURRENCY PAID OR BILLED	TOTAL CHARGE PAID OR BILLED

11. PROVIDE PROOF OF SERVICES WITH THE FOLLOWING:

☐ AN ITEMIZED BILL FROM THE PROVIDER OF SERVICE, LISTING DATES OF SERVICE, SERVICES PROVIDED, AND DOLLAR AMOUNTS PAID.

12. PROOF OF PAYMENT THROUGH ONE OF THE FOLLOWING (CHECK WHICH METHOD APPLIES):

☐ RECEIPT OF PAYMENT BY PROVIDER FOR CASH PAYMENTS. CASH PAYMENTS MUST ALSO INCLUDE PROOF FOR SOURCE OF FUNDS *(I.E. WIRE TRANSFER, TRAVELERS CHECK, CHECK RECEIPT, CREDIT CARD STATEMENT, BANK STATEMENT)*.

☐ FINANCIAL STATEMENT TO INCLUDE A COPY OF FRONT AND BACK OF CANCELED CHECK MADE OUT TO THE PROVIDER.

☐ CREDIT CARD STATEMENT INCLUDING SERVICE RECEIPT

Mail the completed form to:

International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA

Email: CustomerCare@imglobal.com
Inside US and Canada: 1-800-628-4664
Outside US and Canada: 1-317-655-4500
Fax: 1-317-655-4505

13. I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FORM MUST BE SIGNED. CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE

INSURED'S SIGNATURE DATE SUBSCRIBER'S SIGNATURE IF INSURED IS A MINOR DATE

GlobeHopper℠ Senior - Help Sheet

Claim Form Help Sheet

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Field Number	Field Name	Description
1.	Insured ID#	Number found on front of IMG ID card
2.	Insured Date of Birth/Gender	Month (2 digits), Day (2 digits), Year (4 digits) M = Male, F = Female
3.	Insured Name	Surname, Given name and Middle initial
4.	Insured Address	Address for Claims information and Explanation of Benefits
5.	Medicare ID#	Number listed on Medicare Card
6.	Medicare Plan Type	Circle Medicare Plan number(s) enrolled under A – Hospital B – Medical C – Advantage D – Rx Drugs
7.	Medigap Plan	Circle Medigap plan type (Should be on the front of the ID Card) A B C D E F G K L M N
8.	Medicare Advantage or Medigap Policy # and Insurance Information	Name of Insurance Carrier and contact information
9.	Diagnosis	Detailed description of illness or injury
10.	Treatment Information	The date(s) the services were provided to the Insured and the name and address of the provider. Detailed description of procedures, services, or supplies provided, and currency and amount paid for services
11.	Proof of Service(s)	An itemized listing of services and payment from the practitioner or facility
12.	Proof of Payment	Documentation that validates and proves your payment
13.	Signature of Insured	Form must be signed by Insured

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CustomerCare@imglobal.com
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Outside US and Canada: 1-317-655-4500
Fax: 1-317-655-4505