IMG Maestro Claim Form

Must be submitted to International Medical Group®, Inc. (IMG®) within 180 days of date of service.

MAESTRO℠
HARMONY IN HEALTHCARE

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

» If this is a new claim, complete ALL PARTS of this form. If you are not requesting reimbursement you do not need to complete PART C.
» If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also 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 that 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

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

PART A. Claimant/Patient information - To be completed and signed by the Claimant for all claims.

CLAIMANT/PATIENT NAME: (SURNAME, FIRST, INITIAL)		
☐ MALE ☐ FEMALE		DATE OF BIRTH: (DD/MMM/YYYY)
CLAIMANT'S RELATIONSHIP TO PRIMARY INSURED ☐ Self ☐Spouse ☐ Child ☐ Other		
NAME OF PRIMARY INSURED: (AS APPEARS ON ID CARD)		
☐ MALE ☐ FEMALE		DATE OF BIRTH: (DD/MMM/YYYY)
CLAIMS CORRESPONDENCE ADDRESS:		
HOME PHONE:	MOBILE PHONE:	EMAIL:
CERTIFICATE #: (AS APPEARS ON ID CARD)		ID #: (AS APPEARS ON ID CARD)

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

NAME OF PRIMARY INSURED: (AS APPEARS ON ID CARD)		DATE OF BIRTH: (DD/MMM/YYYY)
GROUP NAME OR # OF OTHER PLAN:	POLICY # OF OTHER PLAN:	
NAME OF OTHER CARRIER:		
CARRIER ADDRESS:		
CITY:	STATE/PROVENCE:	POSTAL CODE:
COUNTRY:		

PART B. Claims Information

HOW DID ILLNESS/CONDITION OCCUR?	DATE OCCURED: (DD/MMM/YYYY)
WHERE DID IT OCCUR?	
IF INJURY, DID IT OCCUR WHILE WORKING? ☐ YES ☐ NO	
IF INJURY, WAS IT DUE TO AN AUTO ACCIDENT? ☐ YES ☐ NO	
HAVE YOU EVER BEEN TREATED FOR THIS ILLNESS/CONDITION BEFORE? ☐ YES ☐ NO IF YES, PLEASE PROVIDE DETAILS, NAME AND ADDRESS OF THE TREATING PHYSICIAN ALONG WITH DATE(S) OF THE TREATMENT.	

PART C. Complete for all treatment received where insured has paid and requests reimbursement.

Date of Service *dd/mmm/yyyy*	Provider	What type of service was provided?	What was the condition/ injury?	City/Country	Type of currency paid or billed	Total charge paid or billed	Converted to U.S. funds	Office use only

PART D. Claims Reimbursement- Alternate Payee Request- Must be completed by Parent or Guardian if insured is under 18 years of age. An alternate payee may be elected to receive payment by draft (in USD only), when requested payment is to someone other than insured or provider of medical service(s).

PRINT NAME OF REQUESTED ALTERNATE PAYEE:

PRINT MAILING ADDRESS FOR ALTERNATE PAYEE DRAFT, IF REQUESTING A DIFFERENT LOCATION THAN THE INSURED:

Wire Transfer Request- If payment is to be sent by wire tranfer, please indicate below by completing full details of bank and/or transfer information (Wire cannot be honored if below is incomplete or inaccurate. If no currency is requested, claims will be settled in USD).

NAME OF ACCOUNT HOLDER: (HOW IT APPEARS ON ACCOUNT)

BANK ACCOUNT (U.S.) OR IBAN (NON-U.S.):

SORT OR SWIFT CODE (NON-U.S. BANK):

ROUTING NUMBER (U.S. BANK):

REQUESTED CURRENCY FOR TRANSFER:

BANK NAME:

BANK PHONE NUMBER:

BANK ADDRESS:

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 _____

Signature of Insured/Guardian _____ Date _____
dd/mmm/yyyy

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

Signature of Insured/Guardian _____ Date _____
dd/mmm/yyyy