

Overseas Benefit Request Form

International Medical Group®, Inc.
 P.O. Box 88509, Indianapolis, IN 46208-0509
 Phone: 317.655.4500 or 1.800.628.4664
 Fax: 317.655.4505



Patient: _____ Group No.: _____ ID No.: _____	Email: _____ *A Benefit Request Form must be completed for overseas charges.
---	---

Summary of Services Rendered

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