{ ACH or Wire Transfer Form }

ACH Wire Transfer Request: If you would like IMG to use Direct Deposit to send reimbursement for medical claims or other reimbursable medical costs paid out by you as a member, please indicate below by completing full details of bank and transfer information.

Name of Member: _____

IMG Member ID or NSPID*: _____

Name of Account Holder (exactly as it appears on the account): _____

Bank Account Number: _____ Routing Number: _____

Bank Name: _____ Bank Phone Number: _____

Bank Address: _____

*The IMG Member ID can be found on your ID card issued by IMG. The NSPID is your personal identification number issued by AmeriCorps, you may find this number by accessing your account on the My AmeriCorps portal.

I hereby authorize International Medical Group, Inc. (IMG) to electronically credit my account for the reimbursement of eligible medical costs as allowable under the AmeriCorps VISTA health benefit program. I understand that this authorization will remain in force until revoked by me in writing.

Member Signature: _____ Date:_____

You may submit completed form to IMG by:

Email: vistacare@imglobal.com
Fax: (855) 851-2971
Postal Mail: IMG
P.O. Box 88506
Indianapolis, IN 46208