Health Benefit Plan Claim Form

INSTRUCTIONS FOR FILING CLAIM

1. Please fully complete this side of form.
2. Mail this form and any other bills to: I**MG P.O. Box 88506 Indianapolis, IN 46208** or send via fax to **855-851-2971.**
3. Please contact this office if you have any questions at **855-851-2974 or 317-833-1711** or **vistacare@imglobal.com.**

To expedite the processing of your claim please make sure the diagnosis code, procedure code and provider PIN# (if known) are included on the claim and/or receipts.

TO BE COMPLETED BY PARTICIPANT

ANSWER ALL QUESTIONS THAT APPLY

Name: _____ Date of Birth: _____

First Middle Initial Last Month Day Year

Home Address: _____

Street City State Zip Code

IMG Member ID: _____

If your address has changed, please visit your MyAmericorps account at my.americorps.gov/mp/login.do to update.

Are any hospital, surgical or medical benefits or services provided under any group, individual, blanket, school, franchise or no-fault auto insurance plan or under any state, federal or other governmental program (i.e. Medicaid)? ☐ Yes ☐ No

If "Yes", give the name and address of the insurance company or other organization providing benefits and the policy numbers.

Are you covered under Social Security (Medicare) Health Insurance?

☐ Yes ☐ No

Identification Number: _____

If "Yes", indicate your coverage by checking the appropriate boxes:

Hospital Only (Part A)
Medical Only (Part B)
Hospital and Medical (Part A & B)

Effective Date: _____

Are you covered under any other health insurance?

☐ Yes ☐ No

Identification Number: _____

Effective Date: _____

Are you covered under medical assistance (Medicaid)?

☐ Yes ☐ No

Identification Number: _____

Effective Date: _____

Was medical condition related to:

A. Employment ☐ Yes ☐ No
B. Accident ☐ Yes ☐ No Date of Accident: _____

Describe illness, injury or symptoms: _____

_____

_____ Date symptoms first appeared: _____

The above information is hereby certified to be true and complete. I agree to reimburse my health plan if this claim for sickness/injury is compensable under Medicare-Medicaid, the Worker's Compensation Act, or similar law, if benefits excluded by the provisions of the contract are paid, if such claim is settled or comprised or in the event of recovery from a third party.

Date: _____ Participants Signature: _____

I permit any physician, pharmacist, hospital or other healthcare provider, any insurer, prepayment organization or other health plan provider to give my health plan or its representative any medical information about the patient listed above, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate claims for benefits. This authorization will remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

Date: _____ Participants Signature: _____

TOTAL CHARGES submitted with this form: $ _____ Issue Payment to: ☐ Participant ☐ Provider

ACH Wire Transfer Request: If payment is to be sent by ACH or wire transfer, please indicate below by completing full details of bank and transfer information.

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

Bank Account Number: _____

Routing Number: _____

Bank Name: _____ Bank Phone Number: _____

Bank Address: _____

I hereby authorize International Medical Group, Inc. (IMG) to electronically credit my account. I understand that this authorization will remain in force until revoked by me in writing.

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