AmeriCorps VISTA
Health Benefit Claim Form

POWERED BY IMG

Please complete this form if you have paid out of pocket.
Include itemized provider statement and any other relevant documentation (proof of payment, other insurance EOB letter, etc.).
Submit the completed form to IMG by secure means at:

E-mail*: **VISTAcare@imglobal.com** Fax: **(855) 851-2971**
Postal Mail: **International Medical Group ATTN: AmeriCorps VISTA Claims, P.O. Box 550, Farmington Hills, MI 48332**
If you have any questions, please call IMG at **(855) 851-2974** or **(317) 833-1711**

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

Part 1

Member Name: *(Last, First, Middle)*

Member ID Number: | Member Date of Birth: __/__/__ (MM/DD/YY)

Home Address:

City: | State/Country: | Postal/Zip Code:

If your address has changed, please visit the MyAmeriCorps portal at https://my.americorps.gov to update.

Part 2

Do you have another individual insurance plan of your own, or are you a dependent on any other group, individual, blanket, school, franchise, or no-fault auto insurance plan that provides hospital, surgical, or medical benefits? ☐ Yes ☐ No

Are you covered under Social Security/Medicare? ☐ Yes ☐ No
Identification Number: _____

If "Yes," indicate your coverage:
- ☐ Hospital Only (Part A)
- ☐ Medical Only (Part B)
- ☐ Hospital and Medical (Part A & B) Effective Date: __/__/__ (MM/DD/YY)

Are you covered under any state, federal, or other governmental program? *(i.e. Medicaid)* ☐ Yes ☐ No
Identification Number: _____
Effective Date: __/__/__ (MM/DD/YY)

If yes to any question, provide the address of the insurance company, claim administrator, or other organization providing benefits and the policy numbers:

Was medical condition related to: *(If yes to either, please submit Injury and Accident Form with claim)*
a. Your service with AmeriCorps? ☐ Yes ☐ No
b. Accident ☐ Yes ☐ No
Date of Accident: __/__/__ (MM/DD/YY)

Part 3

Describe illness, injury or symptoms:

Date symptoms first appeared: __/__/__ (MM/DD/YY)

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.

Signature

Participant Signature: **X** _____ | Date: __/__/__ (MM/DD/YY)

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.

Signature

Participant Signature: **X** _____ | Date: __/__/__ (MM/DD/YY)

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: *(Exactly as it appears on the account)*		
Bank Account Number:	Routing Number:	
Bank Name:	Bank Phone Number:	
Bank Address:		
City:	State/Country:	Postal/Zip Code:

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

Participant Signature: **X** _____	Date: __/__/__ (MM/DD/YY)

**Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or by fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider using any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.*

We are required by the Privacy Act of 1974 (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? Purposes – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. Routine Uses – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. Effects of Nondisclosure – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.