AmeriCorps VISTA

Health Allowance Medical Reimbursement Form

POWERED BY IMG

Please complete this form to receive reimbursement of any eligible out of pocket expenses after filing with your primary healthcare plan.

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**

Please include the following:

- Primary Insurance EOB (Not required for Dental/Vision claims)
- Proof of Payment (Examples: Receipts, Paid Invoice Copies, Pharmacy Receipts with Rx Name, Rx Number, Fill Date, etc.)

Part 1 Member Information:

Member Name: *(Last, First, Middle)*		
NSPID or Member ID #: *(As shown on ID card)*		Member Date of Birth: __/__/__ (MM/DD/YY)
Address:		Daytime Phone Number:
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 Allowance Plan Reimbursement Details:

Type of Expense	Total Paid (Combine Expenses)	Dates of Medical Service When combining expenses, use earliest and latest dates of service for the group of expenses.		Total Requested Amount
		Beginning Date	Ending Date	
Deductible				
Coinsurance				
Co-Payment				
Other Qualified Medical Expenses				
			Total amount for all expenses:	

Methon of Reimbursement: ☐ Check ☐ ACH *(please complete page 2)*

Part 3 Member Certification for Reimbursement:

I hereby certify all of the following:

- The above information is correct.
- I have not previously received reimbursement for these expenses.
- I hereby authorize IMG or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, and other insurers in order to consider this submission for reimbursement.

Signature

Member 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.

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)

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