Claim Filing Instructions & Claim Form

Please follow these instructions prior to filing a claim and when completing the Claim Form. Assistance is also available from the IMG Customer Service Department at the telephone numbers listed below.

IF YOU HAVE NOT YET RECEIVED TREATMENT:

Pre-certification (notification of illness or accident):
You must call IMG to pre-certify any of the following conditions: any treatment requiring hospitalisation; outpatient surgery, CAT scans, MRIs; notification within the first 90 days of pregnancy; within 48 hours after an emergency admission to the hospital; care in an extended care facility; home nursing care; durable medical equipment including artificial limbs; or transplants. Pre-certification may be done by you, a relative, or a hospital representative.

When receiving treatment from a medical facility, please follow these instructions:

Present your IMG medical identification card to the medical facility.
Request that they send the bill directly to IMG Europe. Please note, if you pay directly to the medical facility for an eligible expense this may affect your reimbursement from IMG. The negotiated cost of services will be the maximum reimbursement, whether paid to the medical facility or to you.
Complete the Claim Form and submit it with all original bills or invoices. If the medical facility has invoiced IMG Europe on your behalf, simply forward the completed Claim Form to IMG Europe.

IF YOU HAVE ALREADY RECEIVED TREATMENT:

If this is a new claim, complete *ALL PARTS* of the Claim Form.
If this is a continuing claim, complete PARTS A, C AND D.
Attach all original itemised bills, statements and invoices for services and supplies.
Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemised charges.

Mail the completed form to:

IMG Europe Ltd
36 - 38 Church Road
Burgess Hill
West Sussex RH15 9AE
England

For additional assistance:
Phone number: **44 (0) 1444 465577**
Fax: **44 (0) 1444 465550**
E-Mail: **claims@imgeurope.co.uk**

Our aim at IMG Europe is to process your claim quickly, accurately and efficiently. In order to achieve this, the Claim Form must be fully and accurately completed. Failure to do this will result in processing delays.

Updated 3/04

Claim Form & Authorisation

DIRECTIONS FOR SUBMITTING A CLAIM
(There are four parts to this form – A, B, C & D. Please carefully review the instructions below.)

If this a new claim, complete ALL PARTS of this form.
If this is a continuing claim, complete PARTS A, C AND D.
Attach all original itemised bills, statements and invoices for services and supplies.
Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemised charges.

Mail to: **IMG Europe Ltd**
36 - 38 Church Road
Burgess Hill
West Sussex RH15 9AE
England

Notice: Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.

PART A. To be completed and signed by the Claimant for all claims.

Claimant/Patient Name: (as appears on ID card)
☐ Male ☐ Female Date of Birth: dy:mth:yr
Claimant's Relationship to the Insured Person ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Insured: (as appears on ID card)
☐ Male ☐ Female Date of Birth: dy:mth:yr
Home Country Address:
Current Address:
Home Phone: Work Phone: E-mail:
Group # : ID # :
Are you in school full-time? ☐ Yes ☐ No
If yes, please provide name of school and the address:
Are you a U.S. Citizen? ☐ Yes ☐ No
How many months of the year are you in the U.S.?

If Claimant is covered by another plan, complete items below.

Name of Insured Person (as appears on ID card) Date of Birth: dy:mth:yr	
Group # of other plan : ID # of other plan :	
Mailing address	Name of other carrier
City	Carrier address
State Postal Code	City
Name of employer	State Postal Code

PART B. To be completed by the Claimant for new claims only. (If you need additional space, please attach a separate sheet.)

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning. For accidents, include how, when and where the accident occurred.

2. When did the first symptom of this condition begin? State the exact date if possible. dy:mth:yr / /

3. Have you ever had or been treated for this type of injury or illness before? ☐ Yes ☐ No

4. List all the names and addresses of the doctors/hospitals you have seen for this condition.

5. What ailments, diseases, illnesses or injuries have you experienced during the last five years? Please provide the name and/or description of each condition, dates and name and address of the attending physician(s).

6. Is this condition the result of an accident or illness:

a. Related to employment? ☐ Yes ☐ No
If yes, are you applying for Worker's Compensation benefits? ☐ Yes ☐ No

b. Involving a motor vehicle? ☐ Yes ☐ No
If yes, please list the names of involved parties, insurance company and policy numbers.

c. Was a police report filed? ☐ Yes ☐ No
If yes, please identify the Police Department where it was filed.

PART C. Complete for all treatment received outside of the United States.

Date of service dy:mth:yr	Medical Facility	What type of service was provided?	What was the illness/injury?	City/ country	Type of currency paid or billed	Total charge paid or billed	Office use only

PART D. Authorisation - to be completed by the Claimant *for all claims.*

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

I authorise any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to IMG Europe Ltd. or any agent or administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorisation upon request. A copy of this shall be as valid as the original. This authorisation is valid for twelve months from the date signed.

Print Name _____

Signature of Insured/Guardian_____Date_____

AUTHORISATION: I authorise payment of medical costs to the doctor or other supplier of services submitting the attached bills.

Signature of the Insured/Guardian _____Date_____

PRIVACY AND CONFIDENTIALITY RELEASE FORM

By completing this form, you are providing your consent to IMG Europe to discuss your claim activity with the person(s) listed below. Without this release form, IMG Europe cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service.

I authorise IMG Europe to discuss my claim activity with _____.
This authorisation is valid for _____months from the date signed (not to exceed a 12-month period).

I give IMG Europe permission to release any or all of the following information:

(Please select and initial)

☐ _____ All financial and claim information related to medical bills or the Claim Form.
☐ _____ Provider name, date of service, total charge, total paid and date of payment.
☐ _____ Insurance ID number

Under no circumstances can IMG Europe release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

_____ _____
Print Patient Name Insurance ID Number

_____
Signature of the Patient or Insured Person if the patient is a minor child

_____
Date

Mail or fax to:

IMG Europe Ltd
36 - 38 Church Road
Burgess Hill
West Sussex RH15 9AE
England

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