



GEMSM Claim Form

Must be submitted to International Medical Group[®] within 180 days of date of service.

PART A. Who is this Claim for? Primary Insured Dependent

Primary Insured Information

Name:
Male Female Married Single
DOB: \ \
Address:
Telephone:
Email:
Fax:
Policy#:
Name of Employer:

Dependent Information

Male Female Spouse Child
DOB: \ \
Address:
Telephone:
Email:
Fax:
Relationship to insured:
Date dependent insurance began: \ \

PART B. Describe Injury or Illness

Where injury / illness occurred:	Date occurred: \ \
If injury, how it occurred:	
Did injury occur while working?	Yes No
Is injury due to an auto accident?	Yes No
Are you covered by other insurance?	Yes No
Policy #:	
Name of other insurance company:	

PART C. Payment Information

Please furnish an address for an Explanation of Benefits (EOB) and/or a reimbursement.

Address to send funds/EOB:
Electronic Transfer Information
Name of Bank
Name of Bank account holder
Bank location/ address
Bank account number
Bank ID# or ABA/ Swift number

International Medical Group[®], Inc.
P.O. Box 88500
Indianapolis, IN 46208-0500
Intl: 317.655.4500
U.S. & Canada: 800.628.4664
Fax: 317.655.4505

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

Date of service <i>mm/dd/yr</i>	Provider	What type of service was provided?	What was the illness/injury?	City/Country	Type of currency paid or billed	Total charge paid or billed	Converted to U.S. funds	Office use only

PART E. Authorization – 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 authorize 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 International Medical Group[®], Inc. or any agent or administrator acting on its behalf.

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

Print Name _____

Signature of Insured/ Guardian _____ Date _____

AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of the Insured/ Guardian _____ Date _____

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