



# GEO<sup>SM</sup> Group Claim Form

Must be submitted to International Medical Group<sup>®</sup> within 180 days of date of service.

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

**Primary Insured Information**

**Dependent Information**

Name:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single
DOB: \ \
Address:
Telephone:
Email:
Fax:
Policy#:
Name of Employer:

Name:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Spouse <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is injury due to an auto accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you covered by other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policy #:	
Name of other insurance company:	

**PART C.** Wire Transfer Request\*-Complete only if you would like payment made via wire transfer. (Outside U.S. only)

**Please contact your bank if you are unsure of their wire transfer procedures or the fees they may charge for this service.**

Name of account holder: <i>(exactly as it appears on the account)</i>
Phone Number:
Bank account number:
Swift code:
Account currency:
Bank name:
Bank address:

*\*This request applies to this claim only. Minimum wire transfer amount is US\$250. IMG will accept multiple claims to reach the minimum limit.*

Send Explanation of Benefits (EOB) to the address below




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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<sup>®</sup>, 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 \_\_\_\_\_

**International Medical Group<sup>®</sup>, Inc.**  
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