Health Benefit Claim

INSTRUCTIONS FOR FILING CLAIM

1. Please complete this form if you have paid out of pocket.
2. Include itemized provider statement and other insurance EOB (if applicable)
3. Send this form and any other documents to: **IMG P.O. Box 88506 Indianapolis, IN 46208,** via fax to **855-851-2971,** or via email**.**
4. Please contact this office if you have any questions at **855-851-2974** or email to **NCCCcare@imglobal.com.**

TO BE COMPLETED BY MEMBER/PATIENT

ANSWER ALL QUESTIONS THAT APPLY.

Name _____ Date of Birth _____
First Middle Initial Last Month Day Year

Home Address _____
Street City State Zip Code

IMG Member ID (as shown on Healthcare ID Card): _____

If your address has changed, please visit the MyAmeriCorps portal at my.americorps.govmp/login.do to update.

Are you covered under any other health insurance? ◉ Yes ○ No Effective Date: _____

If Yes, please provide the EOB from your primary healthcare plan

Was medical condition related to:

A. your service with AmeriCorps? ◉ Yes ○ No

B. Accident ◉ Yes ○ No Date of Accident: _____

If Yes, please submit an Injury and Accident Form to IMG

Describe illness, injury or symptoms:

Date symptoms first appeared: _____

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.

Date: _____ Member's Signature**:** _____

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.

Date: _____ Member's Signature: _____

TOTAL CHARGES submitted with this form: $ _____ Issue Payment to: ☐ Member ☐ Provider