INTERNATIONAL MEDICAL GROUP

Healthcare Allowance Medical Reimbursement Form

Instructions for filing for Allowance Plan reimbursement:

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

2. Submit this form and EOB or Paid Invoice attachments to IMG by mail at:
IMG Claim Dept., PO Box 88506, Indianapolis, IN 46208-0500
or by secure e-mail at **vistacare@imglobal.com** or by secure fax at **(855)-851-2971.**

Part I: Member Information (Please print)

Member Name (Last/First/MI): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Telephone Number: _____

If your address has changed, please visit your MyAmeriCorps account at **my.americorps.gov/mp/login/** to update.

Allowance Plan Member ID or NSPID # (as shown on your ID card): _____

Part II: 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:	

Method of Reimbursement: Check ☐ ACH ☐ (Please complete and submit ACH Form)

Part III: 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.

Member Signature: _____ **Date:** _____