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:** _____

Privacy Act Statement: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? **Purposes** – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. **Routine Uses** – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. **Effects of Nondisclosure** – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.

Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.