Health Benefit Plan Claim Form

INSTRUCTIONS FOR FILING CLAIM

1. Please fully complete this side of form.
2. Mail this form and any other bills to: **IMG, Attn: Peace Corps Care, P.O. Box 88506 Indianapolis, IN 46208** or send via fax to **855.731.9443.**
3. Please contact this office if you have any questions at **855.731.9442 or collect at 317.927.6825 or pccare@imglobal.com.**

To expedite the processing of your claim please make sure the diagnosis code, procedure code and provider PIN# (if known) are included on the claim and/or receipts.

TO BE COMPLETED BY VOLUNTEER **ANSWER ALL QUESTIONS THAT APPLY**

Name: ____
First Middle Initial Last

Date of Birth: ______________________
Month Day Year

Home Address: ____
Street City State Zip Code

Volunteer ID: ____

Are any hospital, surgical or medical benefits or services provided under any group, individual, blanket, school, franchise or no-fault auto insurance plan or under any state, federal or other governmental program (i.e. Medicaid)? ☐ Yes ☐ No

If "Yes", give the name and address of the insurance company or other organization providing benefits and the policy numbers.

____

Are you covered under Social Security (Medicare) Health Insurance?

☐ Yes ☐ No

Identification Number: ________________

If "Yes", indicate your coverage by checking the appropriate boxes:
Hospital Only (Part A)
Medical Only (Part B)
Hospital and Medical (Part A & B)

Effective Date: ______________________

Are you covered under any other health insurance?

☐ Yes ☐ No

Identification Number: ______________

Effective Date: ____________________

Have you submitted form CA-1 or CA - 2 for consideration under worker's compensation, via the Federal Employee Compensation Act (FECA) for this condition?

☐ Yes ☐ No

Identification Number: ____________

Effective Date: __________________

Was medical condition related to:

A. Employment ☐ Yes ☐ No
B. Accident ☐ Yes ☐ No Date of Accident: _______________

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: ____________________________ Claimant 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: ____________________________ Claimant Signature: ____

TOTAL CHARGES submitted with this form: $ ________________________ Issue Payment to: ☐ Participant ☐ Provider

ACH Wire Transfer Request: If payment is to be sent by ACH or wire transfer, please indicate below by completing full details of bank and transfer information.

Name of Account Holder (How it appears on the account): ___________________________________

Bank Account Number: ___________________________

Routing Number: ________________________________

Bank Name: ______________________ Bank Phone Number: ________________________

Bank Address: ____ IBAN Number or Swift Code (required for Wire transfer outside the US)

I hereby authorize International Medical Group, Inc. (IMG) to electronically credit my account. I understand that this authorization will remain in force until revoked by me in writing.

Signature: ____ Date: ______________________________

You may submit completed form to IMG by:

Email: pccare@imglobal.com
Fax: 855-731-9443
Postal Mail: IMG
Attn: Peace Corps Care
P.O. Box 88506
Indianapolis, IN 46208

FRAUD NOTICES

General: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime , and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.