IPMG
INSURANCE PROGRAM MANAGERS GROUP
EMPLOYEE BENEFITS SERVICES

CLAIMS FORM

HOW TO FILE A CLAIM:

1. To be completed by Employee
2. Please type or print, filling this form out completely.
3. Retain original copies of this form and documentation for your files as once submitted they will not be returned.
4. Sign and date this Claim Form as we will not process unsigned or undated forms.
5. Attach a copy of your eligible medical expenses with the bill or receipt. Documentation must include date(s) of services, type of expense, amount of expense and the name of the provider. NOTE: If you or a dependent are covered by two health plans, attach the Explanation of Benefits Worksheet from the other plan to claim the amount not paid by that plan.
6. Submit via:

MAIL	FAX	WEBSITE FORM
Claims Department IPMG EBS	Claims Department IPMG EBS	www.ipmgbenefits.com
225 Smith Road	Fax: 1-630-789-2093	
St. Charles, IL 60174	Phone: 1-800-423-1841	

EMPLOYEE INFORMATION

Employee Name: ______________________ Claim Type: ☐ Medical ☐ Dental ☐ Vision

Social Security No: ______________________ Eployment Status: ☐ Active ☐ Retired

Address: ______________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Seperatated

Employers: ______________________

SPOUSE INFORMATION

Spouse Name: ______________________

Is Spouse Employed? ☐ Yes ☐ No If Yes, Employer Name: ______________________

Employer Address: ______________________

OTHER INSURANCE INFORMATION

Are you, your spouse or your dependent children entitled to benefits from any other kind of group health care plan including union welfare plans, Medicare, or school insurance? ☐ Yes ☐ No

If "Yes", please provide the name of the organization sponsoring the coverage and identify the family member covered under the other plan.

Organization:

Family Member's Name (include last name if different) and Family Member's Relationship to Employee

______________________ ☐ Medical ☐ Dental ☐ Vision

______________________ ☐ Medical ☐ Dental ☐ Vision

______________________ ☐ Medical ☐ Dental ☐ Vision

______________________ ☐ Medical ☐ Dental ☐ Vision

PATIENT INFORMATION (complete if the informaiton is not provided on bill(s):

Patient Relationship to Employee: ☐ Spouse ☐ Child ☐ Other

If "Other", explain: ______________________

Dependent Name: ______________________ Date of Birth: ______________

Is dependent child a full-time student? ☐ Yes ☐ No

If "Yes" and over age 18, indicate name and address of school

School Name: ______________________

School Address: ______________________

CLAIM INFORMATION (complete if the informaiton is not provided on bill(s):

Reason for Claim: ☐ Accident ☐ Injury

Did sickness or injury arise out of and in the course of any employment? ☐ Yes ☐ No

How? ______________________

When? ______________________

Where? ______________________

Date Of Service? ______________________

Provider? ______________________

Amount? ______________________

INFORMATION RELEASE

To all physicians, hospitals, clinics, dispensaries, sanitariums, druggists, and all other agencies (including other insurance companies), you are authorized to permit IPMG Employee Benefits Services or its representative to obtain or view a copy of your records pertaining to my examination, treatment, history, prescriptions, and medical expenses.

______________________ ______________________

Patienet's Signature (Parent, if patient is a minor) Date

PAYMENT AUTHORIZATION

☐ Please reimburse me of services ☐ Please pay benefits to physician or other supplier

Payment Authorization Date: ______________

______________________ ______________________

Patienet's Signature (Parent, if patient is a minor) Date