

MEDICAL EXPENSES CLAIM FORM

Group Hospital - Surgical - Medical
International Risk Management Group
3359 Route 413
Doylestown, PA 18902
(215)794-1488

INSTRUCTIONS:

1. Complete the Member's Statement Below.
2. Return form and attachments to:
International Risk Management Group
3359 Route 413
Doylestown, PA 18902

(PLEASE PRINT)	PART A	TO BE COMPLETED BY THE INSURED	
1. Name of Insured Person	Name of Group	Group ID #	
City & State	Zip	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <input type="checkbox"/> Married <input type="checkbox"/> Single
3. Claim is made for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried Child (check one) <input type="checkbox"/> Unmarried Student attending (Name of School) _____ Is spouse or child covered by their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Name _____			
4. Name of dependent for whom claim is being made		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
5. Nature of Illness			
Date a doctor was seen for this condition		Doctor's Name and Address	
Was hospital confinement required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Hospital	
Has a doctor been seen for this or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s): _____			
Doctor's Name and Address			
6. Name and Address of Family Doctor			
7. If claim is based on an accident:			
Was the accident due to injured person's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date Occurred	Time	Where did accident occur?	
How did accident happen?			
8. Is claimant entitled to additional benefits under:		Yes	No
a. Group Insurance or any other arrangement of coverage for individuals in a group?		<input type="checkbox"/>	<input type="checkbox"/>
b. Blue Cross, Blue Shield or any other prepayment arrangement?		<input type="checkbox"/>	<input type="checkbox"/>
c. Any coverage for students which is sponsored by or provided through a school or other educational institute?		<input type="checkbox"/>	<input type="checkbox"/>
d. Any federal, state, or other governmental program?		<input type="checkbox"/>	<input type="checkbox"/>
If answer to any of above is YES complete the following:		Policy No.	
Insured	Name & Address of Insurance company or organization		
You			
Spouse			
Child			

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I Hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services as described below ♦ but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON)



INTERNATIONAL RISK MANAGEMENT GROUP

18 East Court Street • Monument Square • 3359 Route 413 • Doylestown, PA 18902
215.794.1488 • FAX 215.794.1498 • 1.888.622.IRMG
www.IRMGroup.com

AUTHORIZATION & ACKNOWLEDGEMENT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give to International Risk Management Group any and all such information.

I UNDERSTAND the purpose of this Authorization is to allow International Risk Management Group to determine eligibility for life or health insurance benefits under a life or health policy. Any information obtained will not be released by International Risk Management Group, to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organization performing business or legal services in connection with my policy, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and a half years from the date shown below.

Signature: _____

Signed this _____ day of _____, 20_____