CLAIM FORM





# HOW TO FILE A CLAIM

1. Claim form must be completed by the employee and include all requested information or it may be delayed or denied.
2. This form must be legible; typed or printed is preferred.
3. Keep a copy of this form and your receipts for your records.
4. This form cannot be accepted without a signature and date.
5. This form must be sent with a copy of the receipt and encounter form from the service. This must include:
   1. Provider name, address, and phone number
   2. Provider TIN
   3. Provider NPI
   4. CPT and DX Code
   5. Amount being requested
   6. Date of service
   7. Your provider should be able to supply you with a billing form or statement that includes all needed information
6. If you or a dependent has other insurance, please include a copy of the EOB from that insurance.
7. Please include an email address or phone number we can reach you at if we need further information.

MAIL

Claims Department IPMG EBS

225 Smith Road St. Charles, IL 60174

FAX

Claim Department IPMG EBS

Fax: 1-630-789-2093

Phone: 1-800-423-1841

WEBSITE FORM

[www.ipmg.com/ebs](http://www.ipmg.com/ebs)

# EMPLOYEE INFORMATION

Employee Name: Claim Type: Medical Dental Vision

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| IPMG ID Number: |  |  | Employment Status: | Active | Retired |
| Address: |  |  |  |  |  |
| Marital Status: | Single | Married | Divorced Legally Separated |  | Widowed |
| Employer: |  |  |  |  |  |
| Email Address: |  |  | Phone Number: |  |  |

# 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 Family Member’s Relationship to Employee (include last name if different)

Medical Dental Vision

Medical Dental Vision

Medical Dental Vision

Medical Dental Vision

**PATIENT INFORMATION (Complete if claim is for spouse or child)**

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 information is not provided on the 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 Total Broker Benefits or its representative to obtain or view a copy of your records pertaining to my exam- ination, treatment, history, prescriptions, and medical expenses.

Patient’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 D Patient’s Signature (Parent, if patient is a minor) Date

**Please make sure you have included all the requested information so IPMG can process your claim in a timely manner. Absence of needed information can cause a delay or rejection of your claim. If you have questions, reach out to our customer service department at 800-423-1841. Our team of representatives will be happy to guide you though this process and work with you to avoid any delays.**