CLAIM 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	*Claim Department*	www.ipmg.com/ebs
IPMG EBS	**IPMG EBS**	
225 Smith Road	Fax: 1-630-789-2093	
St. Charles, IL 60174	Phone: 1-800-423-1841	

EMPLOYEE INFORMATION

Last Name ______________________

First Name ______________________

Social Security Number
Or Alternate ID Number ______________________

Address ______________________

Employer ______________________

Type of claim ☐ Medical ☐ Dental

Employment status ☐ Active ☐ Retired

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

SPOUSE INFORMATION

Last Name ______________ First Name ______________ M.I. ______

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. ☐ Yes ☐ No

Organization Name ______________________

Family Member's Name (include Last Name if different)	Family Member's Relationship to Employee	Please check type of coverage the organization is providing
		☐ Health ☐ Dental
		☐ Health ☐ Dental
		☐ Health ☐ Dental
		☐ Health ☐ Dental

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

Patient Relationship to Employee ☐ Spouse ☐ Child ☐ Other If Other, explain ______________

Name (include Last Name if different) ______________ Birth date ______________

If dependent child, Full Time Student? ☐ Yes ☐ No

If Yes and over 18, 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? ______________

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 examination, treatment, history, prescriptions, and medical expenses.

______________________ ______________

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

PAYMENT AUTHORIZATION *(Check One)*

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

______________________ ______________

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