Certificate of Medical Condition

For improved user experience, communication, and efficiency, we recommend you submit your claim online via MyIMG. While most IMG products are available for online claims submissions, please continue to use this form for all other products

> Please print legibly and complete ALL SECTIONS of this form. Mail, fax, or email completed form to:
> **Address:** International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
> **Call:** +1.800.628.4664 or outside U.S. +1.317.655.4500; **Fax:** +1.317.655.4505
> **Email:** customercare@imglobal.com
> www.imglobal.com

In order for this form to be a valid proof of claim, you must attach the original documents and make certain that documentation is legible, indicates patient's name, date of service, diagnosis, procedure and/or type of service along with the itemized charges.
Failure to submit an accurate, completed form will result in processing delays. The insured has a limited time frame in which to submit a complete proof of claim, and IMG, at its option, may deny coverage for proof of claim submitted thereafter, for incomplete proof of claim and/or failure to submit a proof of claim.

CERTIFICATE OF MEDICAL CONDITION/MEDICAL PROVIDER'S STATEMENT

Patient's Name:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Insured's Name:	Patient's Relationship to Insured:
Policy Number:	Policy Purchase Date: ___/___/___ *(MM/ DD/YYYY)*

ATTENDING PHYSICIAN'S STATEMENT—MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN

1. Diagnosis: Nature of sickness/injury causing cancellation/interruption *(Please be specific)*:
   - a. Primary diagnosis of ICD-10 code: _____
   - b. Secondary diagnosis of ICD-10 code: _____
2. When did symptoms of sickness or injury first occur? ___/___/___ *(MM/ DD/YYYY)*
3. When did the patient first consult you for this condition? ___/___/___ *(MM/ DD/YYYY)*
4. If patient was referred from another provider, name of provider, address and telephone number *(With area code)*:
5. Name, address, and telephone number of other medical personnel involved:
6. Was there any medical condition, injury, illness, or sickness that would interfere with the insured's trip? ☐ Yes ☐ No

   If yes, please explain and indicate when patient was determined not to be medically fit to travel: _____
7. List all dates of treatment and services for this condition

Date of Services: ___/___/___ *(MM/ DD/YYYY)*	Describe the Condition/Treatment:
(Please attach a separate sheet if necessary)	

8. Has the patient been hospitalized for this condition or related condition(s)? ☐ Yes ☐ No

   If yes, date of first admission ___/___/___ *(MM/ DD/YYYY)* Date of discharge: ___/___/___ *(MM/ DD/YYYY)*
9. On what date did this condition first prevent or restrict the patient from traveling? ___/___/___ *(MM/ DD/YYYY)*
10. On what date would the patient not be restricted and medically fit to travel?
11. Did you advise the insured to cancel travel plans prior to departure or return home early a result of the sickness or injury?

    ☐ Yes ☐ No If yes, on what date? ___/___/___ *(MM/ DD/YYYY)* Please explain:

    If No, on what date was the insured prevented from participating in the trip? ___/___/___ *(MM/ DD/YYYY)*

12. If condition was related to pregnancy, date of conception: ___/___/___ *(MM/ DD/YYYY)* Expected Delivery Date: ___/___/___ *(MM/ DD/YYYY)*	
13. Was this sickness/injury the sole cause of the patient's medically imposed restrictions? ☐ Yes ☐ No If no, please explain:	
Additional physician comments:	
Signature of Physician:	Date Completed: ___/___/___ *(MM/ DD/YYYY)*
Name of Physician:	Telephone Number *(With area code)*:
Address of Physician:	
Taxpayer ID Number:	Fax Number *(With area code)*: