INSURANCE MANAGEMENT SERVICES
(806) 373-5944 • 1-800-687-5944
www.imstpa.com • P.O. Box 15688 • Amarillo Tx 79105

CLAIM INFORMATION FORM

IMS will not pay claims until Other Insurance Information is provided.
Other Insurance Information must be collected every 12 months.

Instructions Complete required information* and submit form in any of the following ways:

IMS Website https://imstpa.com/forms/ClaimInfo.pdf
By fax to: 806-373-0995
By Email: PA@imsm.net
Print, Mail to: IMS, PO Box 15688, Amarillo TX 79105

1. **Employee Information***

IMS Policyholder / Employee Name _____ Date of Birth ____/____/____

Employer Name: _____

Member ID or last 4 of SSN _____ Phone # _____ Email _____

2. **Other Coverage Information***

Have you, your spouse, or any dependents covered under this IMS plan had any other Medical, Dental, Vision, Medicaid, or Medicare coverage? * ☐ Yes ☐ No

If marking YES to other coverage, please provide a copy of all other Insurance Cards AND complete the below for all members covered on policy.

Policyholders Name_____ Date of Birth ____/____/____
Name of other Insurance carrier _____
Policy # _____ Group# _____ Insurance Carrier Phone # _____
Name and Relationship to policyholder for all covered under this policy _____
_____
_____

Policyholders Name_____ Date of Birth ____/____/____
Name of other Insurance carrier _____
Policy # _____ Group# _____ Insurance Carrier Phone # _____
Name and Relationship to policyholder for all covered under this policy _____
_____
_____

If other coverage is Medicare, please provide the below information for all Medicare participants

Member Name_____
☐ Part A Effective Date ____/____/____
☐ Part B Effective Date ____/____/____
☐ Part D Effective Date ____/____/____

Reason for Medicare coverage:
☐ Age 65 or older
☐ Disabled
☐ End Stage Renal Disease (ESRD)
Date dialysis treatment began ____/____/____

3. **Accidental Details and/or On the Job Injury, only complete if applicable:**
   - **a.** Do you, your spouse or your dependents have current claim that is due to an injury? ☐ Yes ☐ No
   - **b.** Do you or your dependents have a current claim that occurred in the course of employment? ☐ Yes ☐ No

If yes, please explain accident/injury and provide date of injury and where injury occurred.

_____
_____

_____ _____ _____
Employee/Policy Holder Signature Patient's Signature Date