INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

REQUEST FOR SOCIAL SECURITY NUMBER
(PLEASE FILL OUT THE ENTIRE FORM)

Please Send to Eligibility.Department@imsm.net
Using IMS Secure Email or Fax to (806) 373-1136
Phone (806) 373-5944 - Toll Free 1(800) 687-5944

In order to verify eligibility on you and/or your dependent we need the following information. Any delays in receiving this information along with any necessary documentation may cause unnecessary delays in the claims process and the timely payment of claims.

Employee's Name: _____

Group Name: _____

Dependent's Name: _____

Dependent's SSN: _____

I represent that the above answers and statements are true and complete to the best of my knowledge. I understand that the statements made above will be used to verify that the dependent named above is eligible for coverage in accordance with the definition of the dependent as stated in the group plan under which I am covered.

Employee's Signature: _____

Date: _____

Employee's SSN: _____

Medicare Information:

Are you presently or have you ever been enrolled in Medicare Part A or Part B?	**YES** ☐	**NO** ☐
If yes, please complete the following.		
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available)		
Medicare Claim Number:	**Date Of Birth:**(Mo/Day/Year)	
	/ /	
Social Security Number: - -	**Sex: (M/F)**	**Male** ☐ **Female** ☐

For the reason(s) listed below. I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information. I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

Signature of Person Completing This Form _____ **Date:** _____