

**South Carolina Medical Association
Members' Insurance Trust (Group 768)
Prescription Claim Form**

803-798-6207 ♦ 1-800-327-1021
Ext., 237, 239 or 425

Section 1:

Member's Name _____

Home Address _____
(Street Address) (City) (State) (Zip)

Social Security Number _____

Patient's Name _____ Date of Birth _____ Relationship _____

Section 2:

Are the expenses attached related to an accidental injury? Yes _____ No _____

If yes, please give details of how, when and where the accident occurred: _____

Is the accident work related? Yes _____ No _____

Section 3:

Are you covered by any other health insurance plan? Yes _____ No _____

If yes, please provide: _____
(Name of Insurance Company) (Name of Insured)

Are you covered by Medicare? Yes _____ No _____

Date _____ Signature _____

Attached your itemized bills to this form and submit to:

Planned Administrators, Inc
P O Box 6927
Columbia, SC 29260