P.O. Box 6927
Columbia, SC 29260
Telephone: 803-462-0151 / 1-800-768-4375
Fax: 803-870-8012

MEDICAL CLAIM FORM

FOR OFFICE USE ONLY

☐ NEW CLAIM ☐ CONTINUING CLAIM

Claimant should complete the entire form and sign. Be sure all questions are answered. If the question does not apply to your claim, **mark "NA."**

For all expenses claimed, you must attach itemized statements to include: date, type, place of service, and charge.

If you or your dependents are eligible for other benefits under group insurance, Medicare or any other plan of coverage, and the policy is primary over this policy, please provide a copy of the billing from your provider along with a copy of the explanation of benefits (EOB) from your primary insurance company.

Employee Name:	Employer:	Group #: (see your ID card)
Employee Address:		UMID #: (on front of PAI ID card)
Male ☐ Female ☐	Married ☐ Single ☐ Divorced ☐	Date of Birth:
Active ☐ Retired ☐	Last Date Worked:	Claim on: *(please check one)* Self ☐ Dependent ☐
Patient Name:	Relationship:	Date of Birth:
Has this condition been treated in the past? Yes ☐ No ☐	Date First Seen:	Date Last Seen:
Doctor's Name and Address:		
Condition:		Please check one: Illness ☐ Injury ☐
If injury, describe how accident occurred:		
Where did accident occur? (Please check one.) At Work ☐ Home ☐ Auto ☐ Other ☐	Date:	
If auto accident, attach traffic report and list below the name of the party responsible for the accident and the auto insurance carrier's name and address.		

Are you or your dependents eligible for other benefits under group insurance, Medicare, or any other plan of coverage? Yes ☐ No ☐

If yes, list policy information below.

Name and Address of Insurance Company *Policy Number*

_____ _____

_____ _____

I hereby certify that the foregoing statements, including any accompanying statements, are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, or organization to release any information to Planned Administrators, Inc. A copy of this authorization shall be valid as the original.

Employee Signature: _____ Date: _____