South Carolina Department of Social Services

PHYSICIAN OR CURRENT HEALTH SERVICE PROVIDER(S) AND TELEPHONE NUMBERS

Name: _______________________________ Telephone: ____________________________
Address: _____________________________________________________________________

- [ ] Medical  - [ ] Dentist  - [ ] Specialist Type: ____________________________
- [ ] Therapist  - [ ] Other: ____________________________

Name: _______________________________ Telephone: ____________________________
Address: _____________________________________________________________________

- [ ] Medical  - [ ] Dentist  - [ ] Specialist Type: ____________________________
- [ ] Therapist  - [ ] Other: ____________________________

Name: _______________________________ Telephone: ____________________________
Address: _____________________________________________________________________

- [ ] Medical  - [ ] Dentist  - [ ] Specialist Type: ____________________________
- [ ] Therapist  - [ ] Other: ____________________________

Name: _______________________________ Telephone: ____________________________
Address: _____________________________________________________________________

- [ ] Medical  - [ ] Dentist  - [ ] Specialist Type: ____________________________
- [ ] Therapist  - [ ] Other: ____________________________

Name: _______________________________ Telephone: ____________________________
Address: _____________________________________________________________________

- [ ] Medical  - [ ] Dentist  - [ ] Specialist Type: ____________________________
- [ ] Therapist  - [ ] Other: ____________________________

DSS Form 30265 (APR 13)