MOS - MILITARY ONE SOURCE
FOR REPORTING PURPOSES ONLY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☒ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): MOSF0037053
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TOVAR, JOSHUA			3. PATIENT'S BIRTH DATE MM DD YY: 02 05 1987	SEX: M ☒ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial): TOVAR, JOSHUA
5. PATIENT'S ADDRESS (No., Street): 99-426 AIEALANI PL			6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (No., Street): 99-426 AIEALANI PL
CITY: AIEA	STATE: HI		8. RESERVED FOR NUCC USE				CITY: AIEA STATE: HI
ZIP CODE: 96701	TELEPHONE (Include Area Code): (619) 2451082						ZIP CODE: 96701 TELEPHONE (Include Area Code): (619) 2451082
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous): ☐ YES ☒ NO				a. INSURED'S DATE OF BIRTH MM DD YY: 02 05 1987 SEX: M ☒ F ☐
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? ☐ YES ☒ NO				c. INSURANCE PLAN NAME OR PROGRAM NAME: MOS
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. F331 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	14	21	05	14	21	11		MOS		A	85 00	1		NPI	1699008045
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
812344400	☐	☒	565-963	☒ YES ☐ NO	$ 85 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (808) 468-2439
SIGNATURE ON FILE SIGNED DATE	SERENITY COUNSELING SERVI 99-149 MOANALUA RD, 201 AEIA HI 96701 a. 1588011043 b.	SERENITY COUNSELING SERVI 99-149 MOANALUA RD, 201 AEIA HI 96701 a. 1588011043 b.