

MOS - MILITARY ONE SOURCE FOR REPORTING PURPOSES ONLY

IEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC	6) 02/12 Haganas e codicos dispelest						PICA T	
	HAMPVA GROUP	FEOA	OTHER	1a. INSURED'S I.D. NUM	DED	/Cov	Program in Item 1)	
	HAMPVA GROUP HEALTH F Member ID#) (ID#)	PLAN FECA BLK LUNG (ID#)	VID#)	MOSF003705		(1-01	en en predes ore	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	g transfer in the property to the	TUDATE 6				ama Middla	Initial	
		3. PATIENT'S BIRTH DATE SEX 02 05 1987 X F			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
TOVAR, JOSHUA 5. PATIENT'S ADDRESS (No., Street)	the second secon	6. PATIENT RELATIONSHIP TO INSURED			TOVAR , JOSHUA 7. INSURED'S ADDRESS (No., Street)			
common for the receive amore also, as your analysis on and an embed in the entitle of					99-426 AIEALANI PL			
99-426 AIEALANI PL			Other		LALANT	ЪГ	T==.==	
Comment of the Commen		8. RESERVED FOR NUCC USE		CITY street street tespes most n		STATE		
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96701 (619) 2451082	e langia reforçiyin di thab	estory you of thebland basis but areas to emigd be			96701 (619) 2451082			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	al) 10. IS PATIENT'S	10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
cian service. 3) they must be of leads commenty lurgished to	seyriq beenga a to hed.	in integral, sittodajn indidettini bart of etigovero			physician's die physician's die chiproyec, 2), they must be			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT	a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH SEX			
informed Between to a civelen amployee of the United State	e day anigmber of the C	YES X NO			02 05 1987 MX F			
b. RESERVED FOR NUCC USE	b. AUTO ACCIDE	b. AUTO ACCIDENT? PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)			
		YES X NO			101 X2645 € 30E			
c. RESERVED FOR NUCC USE	c. OTHER ACCID	c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME			
form, may upon convectors be subject to line and Impreprime	eiru ya ji isteeupen ab iur	YES X NO			MOS and laterosceri subtrail to an			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODE	10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
ING INFOPMATION (PRIVACY ACT STATEMENT)	ACA, AMD BLACK LI	10d. CLAIM CODES (Designated by NOCC)			NUCLEUM AND SECTION OF SECTION			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.				YES X NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary				payment of medical benefits to the undersigned physician or supplier for				
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				services described below.				
SIGNATURE ON FILE				SIGNATURE ON FILE				
SIGNEDDATE				SIGNED				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE				16. DATES PATIENT UNA MM DD	ABLE TO WORK	IN CURREN	IT OCCUPATION DD YY	
QUAL.				FROM	At timeta ni	ТО	a especial of	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY				
and the ref of the setting results and the setting of the setting				FROM TO TO TO THE STATE OF THE				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES				
consistent of Notice of Systems of Records," Federal Register Vol. 55 No. 40, West Feb. 25, 1979, See LiSA & ESA				YES X NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				22. RESUBMISSION ORIGINAL REF. NO.				
F331				enulare of (6)33096 9 3.4				
E. L. G. L. H.				23. PRIOR AUTHORIZATION NUMBER				
Health and Human Services and/or the Dopt, of Transporting	HOLITINE USE countered and existed documents mu							
24. A. DATE(S) OF SERVICE B. C. D.	PROCEDURES, SERVICES	S, OR SUPPLIES] E.	F. San F. San Carlo	G. H. DAYS EPSDT	T.	y J. altanete 190	
From To PLACE OF MM DD YY MM DD YY SERVICE EMG C	(Explain Unusual Circums PT/HCPCS I	stances) MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	OR [Family]	ID. UAL.	RENDERING PROVIDER ID. #	
MINI DD 11 MINI DD 11 SERVICE EING C	FI/HCFC5 N	WODIFIER	POINTER	\$ CHARGES	UNITS Plan Q	UAL.	PROVIDER ID. #	
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATI	ENT'S ACCOUNT NO.	27. ACCEPT ASS (For govt. claims,	IGNMENT? see back)	28. TOTAL CHARGE	29. AMOUN	T PAID	30. Rsvd for NUCC Use	
812344400 X 565	-963		NO	\$ 85 00	\$	0 00) SAUTAI SUS	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # (808) 468-2439				
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse SER	ENTTY COINS	TY COUNSELING SERVI			SERENITY COUNSELING SERVI			
the state of the s		MOANALUA RD, 201			99-149 MOANALUA RD, 201			
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SIGNED DATE 158	OUTIO42	ZU43 P			4588011043 b.			