Naval Health Clinic Charleston
Medical Services CRS Accounts

** Required Field*

* First Name:	
* Last Name:	
DoD ID Number:	
* Mailing Address:	
* City/FPO/APO:	
* Country:	United States
* State:	
* Zip Code:	
* Phone Number:	

Refer to your invoice remittance notice and enter the following.

CRS Invoice Number:	Agency Reference Number:	Amount:
*		

Individual case numbers are optional, not required.

	Case Number		Case Number		Case Number
1.		16.		31.	
2.		17.		32.	
3.		18.		33.	
4.		19.		34.	
5.		20.		35.	
6.		21.		36.	
7.		22.		37.	
8.		23.		38.	
9.		24.		39.	
10.		25.		40.	
11.		26.		41.	
12.		27.		42.	
13.		28.		43.	
14.		29.		44.	
15.		30.		45.	