Provider Check Tracer Request Form

Date _____ / __/____
Fax to 714-908-7667
Attn: Claims Department

Requestor information *(person requesting the information)*

Requestor name: _____

Requestor address: _____

City State ZIP: _____

Requestor phone Requestor fax: _____

Requestor e-mail address: _____

Provider information

Provider name NPI #:

Practice or facility name: _____

Provider address: _____

City State ZIP: _____

Provider phone Provider fax: _____

Taxpayer name Tax ID #

Check information *If known; or to request, please call customer service at (866) 688-9021*

Check number: _____Check amount: _____Check date ___/ __ _/___

Reason for tracer *Please check appropriate box below and separately attach any supporting documentation.*

☐Did not receive check

☐Bank rejected check

☐Other *Please specify.* _____

For Astiva Health Internal use only

☐Check cashed *(copy of front and back of check attached)*

Check sent to _____

☐Stop payment issued on___/___/___ New check # _____

Approval signature _____

Request completed on___/___/____

Please allow 30 business days for processing.

Form available at: www.astivahealth.com