brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

Provider Check Tracer Request Form

Fax to: 657-400-1211

Attn: Provider Data Management

Date ___ /___ /___

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* ***866-255-4795***

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 Brand New Day 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.

CDM_0308201

Form available at www.bndhmo.com

Phone: 866-255-4795 ext 5348 or 5372