



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 Claims department at (949) 989 - 4611*

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