 Provider Check Tracer Request Form

Date / /

**Fax to 855-405-2288**

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 (657)206-8700*

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.*

**Specify for which IPA** *Please check appropriate box below*

* Physician Partners
* Premiercare Health
* NXT
* Northern California Physician Group
* Medcare Partners (HealthPlan)

**For Procare MSO 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.procaremso.com**