



Provider Check Tracer Request Form

Date ____ / ____ / ____

Please email completed form to:

providerservices@integranethealth.com

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 #:

Provider's TIN:

Practice or facility name:

Provider address:

City State ZIP:

Provider phone:

Fax#:

Check information

Check number: _____ Check amount: _____ Check date ____ / ____ / ____

Include: Copy of W9- Must match the pay to box 33 of HCFA 1500/ Box 2 UB 04

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

_____ Did not receive check

_____ Bank rejected check

Other Please specify:

2900 North Loop West

Suite 700

Houston, Texas 77092

P: 281.447.6800 F: 281.447.6800

www. Integranethealth.com

800.994.1388

736 So

Alamo Street

San Antonio, TX 78209

P: 210.664.4020 F: 210.664.4020