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: