LOST CHECK AGREEMENT FORM

Employer Group Name or Group #
Member Name
Address
City State
Phone # (for us to contact you with any questions regarding this form)

Date

Please provide the information requested below regarding your lost check. If this information is not received in our office within 30 days from the date of this letter, we will consider the file closed. Any processing fees must be received in advance. Depending upon the age of the original check reissue may not be available.

This is to certify that check # in the amount of $, has been lost and, if found, will be returned to Interactive Medical Systems.

____ I agree to pay a $35.00 stop payment fee, in advance, and request the above check to be reissued immediately

____ I request a new check be issued after 180-day void period has expired.

If check is inadvertently cashed or deposited by me, I agree to refund the full above amount to Interactive Medical Systems.

If check has cleared, and a photocopy is requested, then I understand that there is a $10.00 processing fee.
If it is determined this check was fraudulently processed, the $10.00 processing fee will be refunded to me.

Please verify the address at the top of this form is correct.
Members: If the address you entered at the top of this form is not the address you have on file with Human Resources, please update your address with your Human Resource Department. Providers: If the address you provided is a change, please contact our office at 800-426-8739.

Depending upon the age of the original check reissue may not be available. This does not guarantee a check reissue. Please call our office at 800-426-8739 with questions.

_______________________________________ _____________________

Claimant or Provider Representative Date

IMS OFFICE USE ONLY

GROUP # BENE # PATIENT:

CHECK # AMOUNT $ ISSUE DATE:

PAYEE:

Interactive Medical Systems
PO Box 1349, Wake Forest, NC 27588
www.ims-tpa.com / www.myhealthplanonline.com
Office (919) 877-9933 | Fax (919) 562-0021