Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive • PO Box 3248
Omaha, Nebraska 68180-0001

Customer Service: 888-592-8961
TTY/TDD: 711
Fax: (402) 398-3809

Check Replacement Form

LCA

Member ID/Provider NPI: ____________________

Date: ____________________

Mailing name and address:*

Member Name:	Member ID Number:	Date of Service:	Date Check Issued:
Claim Number(s):		Check Number:	Check Amount:

Our records show you have received a check from us for the above claim(s) that has not cleared our bank. If you have this check, please return it to us so we may cancel the original and reissue a new one. If the check was lost, or you never received it, please complete and sign the statement below and return this form to us.

We will be happy to issue you a replacement check. Please allow up to six weeks for a replacement check.

***Providers: Payments will be mailed to the address listed on the claim form.[1] Please ensure all claim submissions show your correct address. If the address shown above is different from where initial payment was mailed, please attach a copy of your W9 to this form showing your correct address.**

[1] *Institutional Claims Box 2*
Medical Claims Box 33
Dental Claims Box 53

Sincerely,

Blue Cross and Blue Shield of Nebraska

I certify that the above referenced check is one of the following:

☐ It has been found and I will return it; please issue me a new check.

☐ I never received the original check; please issue me a new check.

I understand I am requesting a replacement check and the original check is no longer valid once Blue Cross and Blue Shield of Nebraska receives this form.

Signature: ____ Date: ______________________________

 Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.