BlueCross BlueShield Nebraska

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

Member Services: 888-592-8961
TTY/TDD: 711
Fax: 402-398-3809

Check Replacement Form
LCA

Member ID/Provider NPI: _____

Date: _____

Mailing Name and Address:

Check Payee Name: _____

Check Payee Address: _____

Check Payee City: _____ State: _____ ZIP: _____

Check Number(s): List up to five checks and related details for each check to be reissued. Without a check number we are unable to process this request.

Check Number (Required): _____

Check Issue Date: _____

Check Amount: _____

Our records show you have received a check(s) from us that has not cleared our bank. If you have this check(s), please return it to us so we may cancel the original and reissue a new one. If the check(s) 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(s). Please allow up to six weeks for a replacement check(s).

Note for Providers: Payments will be mailed to the applicable address box on the claim form received (Institutional claims ox 2, Medical claims box 33 and Dental claims box 53). Please ensure all claim submissions show your correct address. If the address shown above is different from where payment should be received, please attach a copy of your W9 to this form showing your correct address.

I certify that the above-referenced check(s) 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(s); please issue me a new check(s).

I understand I am requesting a replacement check(s) and the original check(s) is no longer valid once Blue Cross and Blue Shield of Nebraska receives this form.

Signature: _____ Date: _____