



Claim Check Trace Form

With this form, Participants may trace a check issued by the MPI Health Plan (not Anthem Blue Cross) for payment of claims. Please fill out all information in this form and return it to MPI.

Mail: **Motion Picture Industry Health Plan
Accounting Dept., Attn: "Check Trace Desk"
P.O. Box 1999, Studio City, CA 91614-0999**

Email: **service@mpiphp.org**

- I did not receive *nor* did I endorse any check for the claim(s) below. I request that MPI "**STOP PAYMENT**" on the original check and issue a replacement check to me. (**Must be at least 30 days from the check issue date**)
- I received a check for the claim(s) below. It is either expired or lost. I request that MPI issue a replacement check to me. (**Requests must be made within seven (7) years of the original check issue date.**)

Participant's Name:		
Patient's Name:		
Provider/Facility's Name:		
Payable to:		
Date of Service:	Amount Paid:	
Claim Number:	Check Number:	
Check Date:	My Daytime Telephone:	
My Address:		
My E-mail Address:		

Requester Name **(Required)** _____

Date _____

Requester Signature **(Required)** _____

PLEASE ALLOW UP TO SIXTY (60) DAYS FOR PROCESSING