



BEP 1
3/2013
Bureau of Eligibility Policy

State of Utah
Department of Health
Division of Medicaid & Health Financing

UPP Lost Check Replacement Form

Information Provided by the Payee

I, _____, confirm that I am unable to locate the UPP check for the month(s) of _____ and request that the State of Utah, Department of Health, stop payment on the original check and issue a replacement check.

Please mail the replacement check to the following address:

Name _____

Address _____

Address _____

City/State/Zip _____

Signature of Payee	Case # or Date of Birth	Telephone #	Date
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When the completed form is returned, the Department of Health will place a stop payment with the bank on the original check and issue a replacement check. If you locate the original check **after** you have returned this form, contact the UPP Administration office at (801) 538-6192. Do not deposit or cash the original check. **Please allow 10 days for processing and mailing of the replacement check.**

Return completed form to:
Department of Health
Bureau of Eligibility Policy
UPP
PO Box 143107
Salt Lake City, UT 84114-3107

Or fax completed form to: (801) 538-6952

For Department of Health Use Only

Payee _____
Original Check Number _____
Check Amount _____ Check Date _____
Duplicate Check Number _____
Date Duplicate Check Mailed/Released _____