BEP 4
1/2020
Bureau of Eligibility Policy

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

ESI Lost Check Replacement Form

Information Provided by the Payee

I, _____, confirm that I am unable to locate the ESI 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: (First, MI, Last):_____
Mailing Address: _____
City, State, Zip Code: _____
Telephone #: (___)_____Date of Birth: _____ Case Number: _____

_____ _____

Signature of Payee Date:

Once the Department of Health receives the completed form, your request will be processed and a replacement check will be issued. If you locate the original check after you have returned this form, do not deposit or cash the check. Contact the ESI Administration office at (801) 538-6192. **Please allow 10 business days for processing and mailing of the replacement check.**

Return completed form to:

Utah Department of Health
Bureau of Eligibility Policy
ESI

Form may be submitted by:

Email: ESI@utah.gov
Fax: (801) 538-6952
Mail: PO Box 143107
SLC, UT 84114-3107

For Department of Health Use Only
Payee _____ Benefit Month: _____
Original Check #:_____ Check Amount: _____ Check Date: _____
Duplicate Check #: _____ Date Mailed: _____ Approved by: _____