Affidavit of Lost, Stolen, or Destroyed Warrant

Washington State Health Care Authority

I, (print name), having been duly sworn, depose and say that I am the proper owner, payee, or legal representative of such owner or payee of the state of Washington's Warrant Number ,

dated, made out to the order of in the amount of

$, and that said warrant has been lost, destroyed or not delivered to me and to the best of my knowledge has not been paid. If the warrant is subsequently found, I will return the warrant.

Payee signature | Payee phone number

Mailing address | City | State | ZIP/Postal code

NOTARY SEAL

State of

County of

I certify that I know or have satisfactory evidence that (name of person) is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated | Signature

Title | My appointment expires

Witnesses: required only if payee signed by mark (x) above

Witness 1

Witness' signature | Date | Print witness' name here

Mailing address | City | State | ZIP/Postal code

Witness 2

Witness' signature | Date | Print witness' name here

Mailing address | City | State | ZIP/Postal code

RETURN TO:
Washington State Health Care Authority
Financial Services/Accounting
PO Box 42691
Olympia, WA 98504-2691

FSA use only

For HCA use **ONLY**

HCA unit contacted | HCA staff name | HCA staff telephone | Issue date

New check number | P1 ID number | Register number | Warrant number

Payee name | Fund | Amount

Payee mailing address | City | State | ZIP/Postal code

Reissued by | Telephone