STATE OF ALASKA
WARRANT STATUS CHANGE REQUEST

GENERAL INSTRUCTIONS FOR STOP PAY/REISSUE AND CANCEL/REISSUE OF STATE WARRANTS

☒ Medical Assistance

In the ***COMPLETED BY PROVIDER AND FAXED TO ACS*** section of this form, the provider enters the warrant number, checks the appropriate box for requesting a warrant to Stop Pay/Reissue, signs the certification, and faxes the form to Affiliated Computer Services (ACS) at **(907) 644-8120**. In the ***AGENCY CERTIFYING OFFICER ACTION*** section, Health Care Services (HCS) will verify that the warrant has not been redeemed and enter the Alaska State Accounting System (AKSAS) transaction information. Once the stop pay transaction processes, ACS will reissue the warrant.

COMPLETED BY PROVIDER AND FAXED TO ACS

Please stop pay and reissue State of Alaska warrant number _____ for the following reason:
(*Note: If the provider does not have the warrant number, the provider may call ACS's Finance Department at **(907) 644-6813***.)

☐ Warrant Destroyed in Error ☐ Warrant Lost ☐ Warrant Never Received ☐ Warrant Stolen ☐ Warrant Damaged

☐ Other (brief explanation): _____

I CERTIFY I HAVE NOT CASHED THIS WARRANT, AND I WILL NOT CASH IT IF FOUND. I understand a replacement warrant, if applicable, cannot be issued until a stop payment posts in the State's Accounting System. If I locate the original warrant, I will immediately mark it void and mail it to:

Affiliated Computer Services, ATTN: Finance, 1835 South Bragaw Street, Ste. 200, Anchorage, AK, 99508-3469

Provider Signature:_____ Phone:_____ Date: _____

ACS USE ONLY

Provider ID	Warrant Number	Amount	Issue Date

Provider Name	Provider Address	City	State	ZIP

ACS Representative	Signature	Date

AGENCY CERTIFYING OFFICER ACTION

I certify that the facts herein and on supporting documents are correct. This transaction constitutes a legal charge against funds and/or appropriations cited, sufficient funds are encumbered to pay this obligation, or that there is a sufficient unencumbered balance in the funds and/or appropriation cited to cover this obligation. I am aware to knowingly make or allow false entries or alterations on a public record, or knowingly destroy, mutilate, suppress, conceal, remove or otherwise impair the verity, legibility or availability of a public record constitutes tampering with public records punishable under *AS 11.56.815-820*. Other disciplinary action may be taken up to and including dismissal.

Date	Certifying Officer's Signature	Telephone Number

Health & Social Services Department	Certifying Officer's Printed Name	Mail Stop Number

HEALTH CARE SERVICES USE ONLY

DISPOSITION:

☐ Warrant cancelled. Reissued warrant number _____.

☐ Warrant cancelled. No reissue.

☐ Warrant cashed. Copy Attached.

_____ _____
Signed Date