CONSUMER DIRECT CARE NETWORK

VENDOR PAYMENT REQUEST FORM

Mail/Drop Off: 2611 South Clark Street, Ste 700
Arlington, VA 22202

Email: InfoCDDC@ConsumerDirectCare.com

Fax: (855) 436-9066

Have Questions? Phone: (844) 381-4432

Requests for Vendor Payments received by Consumer Direct Care Network (CDCN) before 5:00 pm Monday are normally processed for payment by the end of the same week.

For Internal Use Only

☐	Participant Name & ID	☐	W-9*
☐	Vendor Name & Address	☐	Agreement*
☐	Serv. Code Matches Auth	☐	Amount approved
☐	Item/Service Authorized	☐	Funds available

*if needed

- *You are required to submit this form and the matching invoice to Consumer Direct DC no later than 180 days from the date of receiving the service.*
- *CDCN must have authorization from the payer (State, MCO, or County) to process payment for all goods and services.*
- *The goods or services must be listed on the Participant's approved budget.*
- *All receipts and/or invoices must be included with this Vendor Payment Request Form to ensure proper processing.*
- *The Employer is responsible for allowing adequate processing time for payments to be made by due dates.*
- *Incorrect or incomplete Vendor Payment Request Forms may be returned for correction, which will result in delay of payment.*

Name of Individual Receiving Services	**CDCN Participant/Employer ID #**

Make check payable to	**NEW Address – <u>Must</u> check here ☐**
Name	Indicate **<u>NEW</u>** address below
Address	
City/State/Zip	

A vendor providing service(s) **must** submit a new W-9 if changing address.

Date of Invoice (mm/dd/yy)	**Service Code**	**Description of Service**	**Quantity** (Units)	**Rate per Unit**	**Total Dollar Amount**
				Total Check Amount	

Please attach a copy of the voided receipt, agency invoice, or signed bid/estimate.

I approve CDCN to issue payment directly to the above-named Vendor for the services/goods listed above. I certify that the above Vendor provided services in accordance with the plan. Falsification of this Vendor Payment Request is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.

_____ _____ _____/____/_____

Participant/Representative Signature | Print Name | Date (mm/dd/yyyy)