VENDOR PAYMENT REQUEST FORM INSTRUCTIONS

A Vendor Payment Request Form must accompany all requests for vendor payment. Make sure your vendor payment request is filled out completely and correctly. Print all entries neatly. Each receipt or invoice listed must include Date, Service Code, Description, Quantity, Rate and Total. Incorrect, incomplete or illegible forms may result in payment delays.

1. Name of Individual Receiving Services. Print Individual's Name.

2. CDCN Participant/Employer ID. Seven-digit ID number.

3. Make check payable to. Indicate who the check should be made out to. Include Name and full address. Please list one vendor per Request Form.

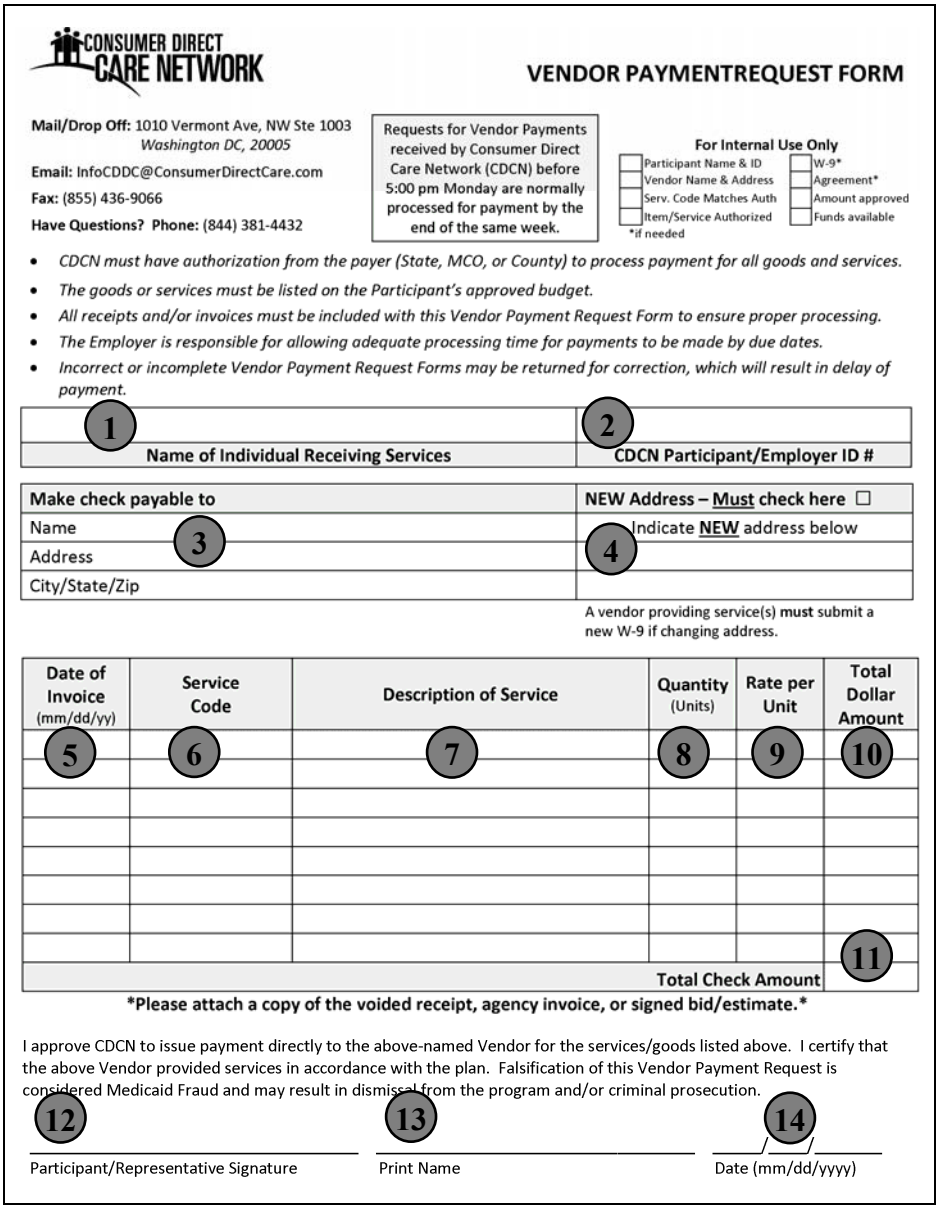
4. New Address. If this vendor has moved since the last time you submitted a request for payment, check the box and fill in the new address. Also submit a new W-9 for this vendor.

5. Date of Invoice. The date on the invoice or receipt. In MM/DD/YY format. Please list each invoice on a separate line, one date per line. Attach a copy of each receipt, invoice, or signed bid/estimate.

6. Service Code. Fill in the Service Code for the service provided on this invoice. Ensure the service code is approved on the budget/auth/plan.

7. Description of Service. Write out what service or good the vendor provided on each invoice/receipt.

8. Quantity. The number of items, units, hours, or times the good or service was provided.



CONSUMER DIRECT CARE NETWORK

VENDOR PAYMENTREQUEST FORM

Mail/Drop Off: 1010 Vermont Ave, NW Ste 1003
Washington DC, 20005
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

- *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.*

1 Name of Individual Receiving Services	2 CDCN Participant/Employer ID #

Make check payable to	NEW Address – Must check here ☐
Name 3	Indicate NEW address below
Address	4
City/State/Zip	

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

Date of Invoice (mm/dd/yy) 5	Service Code 6	Description of Service 7	Quantity (Units) 8	Rate per Unit 9	Total Dollar Amount 10
					11
				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.

12 _____ Participant/Representative Signature

13 _____ Print Name

14 ____/____/____ Date (mm/dd/yyyy)

9. Rate per Unit. The cost for one item, unit, hour, or time of this good or service.

10. Total Dollar Amount. The total amount of this line.

11. Total Check Amount. The total for all invoices to be paid to this vendor.

12. Participant/Representative Signature.

13. Print Name. Print the name of the Participant or Participant's Representative who signs the form.

14. Date. Participant/Representative signature date. In MM/DD/YYYY format. This must be **on or after** the last invoice date. Future signature dates are not accepted and will be returned for correction.