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.

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.

**VENDOR PAYMENT REQUEST FORM**

- **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.