

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.

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Mail/Drop Off: 7951 E. Maplewood, Suite 125 Greenwood Village, CO 80111 Email: CDCOTimesheets@consumerdirectcare.com Fax: 1-866-924-9072 Have Questions? Phone: 1-844-381-4433		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		.g* greement* nount approve	
 The goods or se All receipts and The Employer is 	ervices must be listed on t l/or invoices must be incl s responsible for allowing	payer (State, MCO, or Coun the Participant's approved b uded with this Vendor Paym adequate processing time f returned for correction, who	udget. ent Requ or paym	est Form to ensur ents to be made b	e proper pro y due dates.	ocessing.	
			2)				
Name of Veteran Receiving Services				CDCN Participant/Employer ID #			
Make check payable to			NE	NEW Address – Must check here			
Vendor Name				Indicate <u>NEW</u> address below			
Address 3				4			
City/State/Zip				·			
				endor providing sen v W-9 if changing ac		ubmit a	
Date of Invoice (mm/rt//yy)	Service Code	Description of Servi	ce	Quantity (Units)	Rate per Unit	Total Dollar Appuni	
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he above Vendor p	rovided services in accord	the above-named Vendor for dance with the plan. Falsific from the program	ation of	this Vendor Paym			

- **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. Veteran or Employer Signature.
- **13. Print Name.** Print the name of the Veteran or Employer of Record who signs the form.
- **14. Date.** Date of signature. 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.