Request for Vendor Payment
FAX TO: 610-376-0035

Requesting Agency_____COUNTY_____
Service Coordinator Contact:_SERVICE COORDINATOR_____ **SC Email:**_ SC'S EMAIL ADDRESS

Participant Name: CONSUMER NAME	**Participant ID #:** MEDICAID NUMBER
Month: MONTH OF SERVICE	**Year:** YEAR OF SERVICE

Payment Instructions

Make Check Pavable to: DRIVER OR COMPANY MAKING DELIVERY	**Mail Check to (if different):**
Vendor FEIN or SS#:	**Name:**
Name: SAME AS "MAKE CHECK PAYABLE"	**Address:**
Address: ADDRESS OF DRIVER OR DELIVERING COMPANY	**City, State, Zip:**
City, State, Zip: CITY, STATE, ZIP OF DRIVER/DELIVERING COMPANY	

Date	Service Code	Description	# of Units	Total Amount
DATE OF SERVICE	SERVICE CODE	DESCRIPTION OF SERVICE CODE	NUMBER OF UNITS	TOTAL DOLLAR AMOUNT
			Total Check Amount	

Reminder: Please attach receipt or vendor invoice.

By signing this form, I attest that services were delivered and received consistent with the Individual Support Plan. I understand that Medicaid is the payer of last resort. I have confirmed that the vendor and/or small unlicensed provider have met the waiver qualification criteria that is outlined in the current approved waiver.

Employer's Signature **Date**