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

Requesting Agency_____

Service Coordinator Contact:_____ **SC Email :** _____

Participant Name:	**Participant ID #:**
Month:	**Year:**

Payment Instructions

Make Check Payable to:	**Mail Check to (if different):**
Vendor FEIN or SS#:	**Name:**
Name:	**Address:**
Address:	**City, State, Zip:**
City, State, Zip:	

Date	Service Code	Description	# of Units	Total 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**