Abilities in Motion – Request for Vendor Payment

Email to: Vendor@abilitiesinmotion.org Fax to: 610-376-0035

Requesting Agency (SCO): _____

SC Name: _____ SC Email:_____

Participant Name:	**MA #:**
Month:	**Email:**

Payment Method: ☐ Check ☐ Online Order

Make Check Payable To:	Store(s) ordering from online:
Mail Check to Vendor Name:	Ship item to Name:
Mailing Address:	Shipping Address:
Mailing City, State, Zip:	Shipping City, State, Zip:
Mailing Vendor Phone Number:	Shipping Phone Number:

Please attach receipt, vendor invoice, or online shopping link/description.

Date	Service Code	Description	# Units	Total Amount
			Total Service Amount	

By signing this form, I attest that services requested, delivered, and received are 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.

_____ _____

Consumer / SCO Signature **Date**