



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. If the vendor provides service(s), you will also need to submit a new W-9.

5. Vendor Type. Indicate which type of vendor this is. If marked Agency or IC, you will need to submit that type of agreement to CDCN.

6. 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.

7. 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.

8. Description of Service. Write out what service or good the vendor provided on each invoice/receipt.

9. Quantity. The number of items, units, hours, or times the good or service was provided.

10. Rate per Unit. The cost for one item, unit, hour, or time of this good or service.

11. Total Dollar Amount. The total amount of this line.

12. Total Check Amount. The total for all invoices to be paid to this vendor.

13. Employer/Guardian Signature.

14. Print Name. Print the name of the employer/guardian.

15. Date. Employer/Guardian 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

Mail/Drop Off: 280 E. Corporate Dr, Ste 150
Meridan, ID 83642

Email: infoCDID@ConsumerDirectCare.com

Fax: 877-898-0417

Have Questions? Phone: 877-898-0470

Requests for Vendor Payments are due by midnight on Monday of timesheet week for payment to normally be issued on the following pay date.

For Internal Use Only

Participant Name & ID

Vendor Name & Address

Serv. Code Matches Auth

Item/Service Authorized

W-9*

Agreement*

Amount approved

Funds available

- Consumer Direct Care Network (CDCN) must have authorization from the payer (State, MCO, or County) to process payment for all goods and services.
- The goods or services must be listed on the Participant's approved budget.
- All receipts and/or invoices must be included with this Vendor Payment Request Form to ensure proper processing.
- The Employer is responsible for allowing adequate processing time for payments to be made by due dates.
- Incorrect or incomplete submissions may be returned for correction, which will result in delay of payment.

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Name of Individual Receiving Services	CDCN Participant/Employer ID #

Make check payable to	NEW Address – Must check here <input type="checkbox"/>
Name 3	Indicate NEW address below
Address	4
City/State/Zip	
Vendor is: <input type="checkbox"/> Agency <input type="checkbox"/> Independent Contractor	A vendor providing service(s) must submit a new W-9 if changing address.
<input type="checkbox"/> Other Business, Professional, or Service Provider	

Date of Invoice (mm/dd/yy)	Service Code	Description of Service	Quantity (Units)	Rate per Unit	Total Dollar Amount
6	7	8	9	10	11
Total Check Amount					12

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.

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Employer/Guardian Signature

Print Name

Date (mm/dd/yyyy)