CONSUMER DIRECT CARE NETWORK

# VENDOR PAYMENT REQUEST FORM

**Mail/Drop Off:** 744 Ryan Dr, Ste. 201
*Hudson, WI 54016*

**Email:** infocdwi@consumerdirectcare.com

**Fax:** 1-877-785-9992

**Have Questions? Phone:** 1-877-785-9991

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
- ☐ Vendor Name & Address
- ☐ Serv. Code Matches Auth
- ☐ Item/Service Authorized
- ☐ W-9*
- ☐ Agreement*
- ☐ Amount approved
- ☐ Funds available

*if needed

- *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 Form and submitted within 90 days of service.*
- *The Employer is responsible for allowing adequate processing time for payments to be made by due dates.*
- *Incorrect or incomplete Vendor Payment Request Forms may be returned for correction, which will result in delay of payment.*

| | |
|---|---|
| **Name of Individual Receiving Services** | **CDCN Member/Employer ID #** |

| **Make check payable to** | **NEW Address – Must check here** ☐ |
|---|---|
| Vendor Name | Indicate **NEW** address below |
| Address | |
| City/State/Zip | |

A vendor providing service(s) **must** submit a new W-9 if changing address.

| **Date of Invoice** (mm/dd/yy) | **Service Code** | **Description of Service** | **Clock In Time** | **Clock Out Time** | **Shift entered on EVV?** | **Quantity** (Units) | **Rate per Unit** | **Total Dollar Amount** |
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| | | | | **Total Check Amount** | | | | |

***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.

_____ _____ _____/____/_____

Member/Managing Party Signature | Print Name | Date (mm/dd/yyyy)

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