



4646 S. Biltmore Lane
 Madison, WI 53704
 Phone: 855.201.4230
 Fax: 844.650.1968

VENDOR CHECK REQUEST FORM

Member Name _____

FA Member ID# _____

Make Check Payable To:

Vendor Name/Vendor ID#: _____ Phone: (____) _____

Address: _____

City, State Zip: _____

Date of Invoice	Service Code	Description of Service	Amount

- ✓ FA must have authorization from the MCO or County to process any payment for goods and/or services.
- ✓ This Vendor Payment Request Form must be accompanied with the receipt, invoice or estimate.
- ✓ Payments are processed every other Friday. Please see payment schedule for further details. All requests must be submitted by 4:30 pm on due date to ensure payment is made on the respective Friday.
- ✓ Member or Authorized Party is responsible for allowing adequate processing time to accommodate the respective due dates.
- ✓ Incorrect or incomplete Vendor Check Request Forms will be returned to the Member or Authorized Party for corrections, which may result in delay of payment.

I approve and authorize FA to issue payment to the above named Vendor for the goods and/or services listed above. I certify that the above Vendor provided these goods and/or services in accordance with my care plan. Falsification of this Vendor Check Request is considered Medicaid Fraud and may result in dismissal for the program and/or criminal prosecution.

 Member/Authorized Signature

 Signer's Printed Name

 Date