4646 S. Biltmore Lane
Madison, WI 53718
Phone: 855.201.4230
Fax: 844.650.1968

VENDOR CHECK REQUEST FORM

Member Name ______________________ FA Member ID# ______________________

Make Check Payable to:

Vendor Name: ______________________ 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 From 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 X 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 accomodate the respective due dates.

√ Incorrect or incomplete Vendor Check Request Form 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 crimnal prosecution.

Member/Authorized Signature ______________________ Signer's Printed Name ______________________ Date ______________________