



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/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 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