CONSUMER DIRECT CARE NETWORK

VENDOR PAYMENT REQUEST FORM

Mail/Drop Off: 3782 E Amity Ave, Unit 101
Nampa, ID 83687

Email: infoCDID@ConsumerDirectCare.com

Fax: 877-898-0417

Have Questions? Phone: 888-898-0470

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

- *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.*

Name of Individual Receiving Services	**CDCN Participant/Employer ID #**

Make check payable to	**NEW Address – Must check here** ☐
Name	Indicate **NEW** address below
Address	
City/State/Zip	
Vendor is: ☐ Agency ☐ Independent Contractor ☐ Other Business, Professional, or Service Provider	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**	**Quantity** (Units)	**Rate per Unit**	**Total Dollar Amount**
				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.

_____ _____ _____/____/_____
Employer/Guardian Signature Print Name Date (mm/dd/yyyy)

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