

Vendor Payment Request

Complete all relevant fields below for payment to be sent to a vendor for authorized services in the Individual Support Plan (ISP). DO NOT use your own money to pay vendors, Conduent CANNOT reimburse you. Payment will be generated on the next payroll cycle according to the Payroll Schedule, after Conduent has processed this form, which may take up to five (5) business days. Please make sure the below vendor has properly submitted all paperwork to enroll with Conduent prior to submitting this request. Initial Vendor Payment Request forms must be submitted for payment within ninety (90) days from date of service to meet timely filing requirements. Initial VPRs submitted past ninety (90) days from date of service will be denied for failure to meet Medicaid timely requirements.

REFERENCE #

***Please write a unique reference number for tracking this request in the box above.**

PARTICIPANT INFORMATION		
Full Name	Medicaid ID	Approved Budget Period
VENDOR INFORMATION		
Full Name	FEIN or SS# of Payee	
Vendor Address	City, State, Zip Code:	

**A W-9 is required for all Vendors. All Vendors require a W-9 to be submitted with the Vendor Payment Request form. This form must be filled out and signed by the vendor.*

PAYMENT INFORMATION				
Date of Service	Procedure Code	Service Description & Explanation	Amount (Including all taxes)	Invoice Attached*
			\$	<input type="checkbox"/>
			\$	<input type="checkbox"/>
			\$	<input type="checkbox"/>
TOTAL			\$	

**An itemized invoice MUST be attached. Invoices should only include items included in requests for waiver reimbursement.*

Is this a correction to a PRIOR VPR? <input type="checkbox"/> YES <input type="checkbox"/> NO

Special instructions:

By signing this form, I attest that the vendor is qualified to render this service. I also attest that services were delivered and received consistent with the Individual Support Plan.

Employer Signature	Date

ATTACH A VENDOR INVOICE WITH THIS PAYMENT REQUEST FORM. FUTURE DATED INVOICES WILL NOT BE ACCEPTED.

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