



Vendor Payment Request Form

Complete all relevant fields below for payment to be sent to a vendor for authorized services in the Approved Budget Period. 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. Initial Vendor Payment Request (VPR) Forms must be submitted for payment within ninety (90) days from date of service to meet timely filing requirements.

Is this a correction to a PRIOR VPR?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
PARTICIPANT INFORMATION				
Full Name		Medicaid ID	Approved Budget Period	
VENDOR INFORMATION				
Full Name			FEIN or SSN of Payee	
Vendor Address			City, State, Zip Code	
PAYMENT INFORMATION				
Date of Service	Procedure Code	Service Description & Explanation	Amount (including all taxes)	Invoice Attached*
<i>*An itemized invoice MUST be attached. Invoices should only include approved goods and services.</i>				
DESIRED METHOD OF PAYMENT				
Only select one (1) option:		<input type="checkbox"/> Money Network Card <input type="checkbox"/> Direct Deposit <input type="checkbox"/> Palco Paper Check		
<i>Desired Method of Payment is mandatory. If no selection is made, a Palco Paper Check will be issued.</i>				
ENVIRONMENTAL MODIFICATIONS				
Is the Item being requested for an EMOD?		For Environmental Modifications (EMOD) ONLY		
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> First Installment <input type="checkbox"/> Second Installment/Job Completed		
Special Instructions (Completed by EOR)				
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 Approved Budget Period. I attest that my desired method of payment will comply with program policies. I understand that I must retain a receipt for all purchases and comply with audit requirements.				
_____ EMPLOYER OF RECORD SIGNATURE			_____ DATE	



Please make sure the vendor has properly submitted all paperwork to enroll with Conduent prior to submitting this request. Initial Vendor Payment Request (VPR) Forms must be submitted for payment within ninety (90) days from date of service to meet timely filing requirements. Initially VPRs submitted past ninety (90) days from date of service will be denied for failure to meet Medicaid timely requirements.

- ***ATTACH A VENDOR INVOICE WITH THIS PAYMENT REQUEST FORM. FUTURE DATED INVOICES WILL NOT BE ACCEPTED.***
- ***PLEASE MAKE SURE THE VENDOR HAS PROPERLY SUBMITTED ALL PAPERWORK TO ENROLL WITH CONDUENT PRIOR TO SUBMITTING THIS REQUEST.***
- ***INITIAL VPRs SUBMITTED PAST NINETY (90) DAYS FROM DATES OF SERVICES WILL BE DENIED FOR FAILURE TO MEET MEDICAID TIMELY FILING REQUIREMENTS.***

Please return this form to Conduent via email, fax, or mail.

Fax: 1.866.302.6787

Email: docprocessing@conduent.com

Address: P.O. Box 27460

Albuquerque, NM 87125-7460



Instructions for Vendor Payment Request Form

Below are instructions for completing each section on the Vendor Payment Request (VPR) Form. The Vendor Payment Request form is available on the Palco website at [Home - PALCO \(palcofirst.com\)](http://Home - PALCO (palcofirst.com)).

NOTE: SDCB PCS and/or Respite

If SDCB PCS and/or Respite services are provided by a vendor, you must attach the *Self-Directed Community Benefit (SDCB) Vendor Electronic Visit Verification (EVV) Attestation Form* available on the Palco website at [Home - PALCO \(palcofirst.com\)](http://Home - PALCO (palcofirst.com)).

• **Is this a correction to a PRIOR VPR?**

- Indicate Yes/No if this is a correction to something you have already submitted.

• **Participant Information**

- Full Name: Write the service recipient's full legal name.
- Medicaid ID: Write the service recipient's Medicaid ID number.
- Approved Budget Period: Write the date span of the participant's budget for which this service is approved.

• **Vendor Information**

- Full Name: Write the vendor's full name or business name.
- FEIN or SSN# of Payee: Write the vendor's legal identification number such as their Federal Employer Identification Number (FEIN) or Social Security Number (SSN).
- Vendor Address: Write the address of the vendor or business.
- City, State, Zip Code: Write the vendor's city, state, and zip code.

• **Payment Information**

- Date of Service: The date when services were provided, format: MM/DD/YYYY.
- Procedure Code: The service plan service code (example: 99509).
- Service Code Description & Explanation: A summary of the service (example: cell phone).
- Amount: Dollar amount being requested for this service, including any applicable taxes. This amount should match the amount of the attached invoice.
- Invoice Attached: Check the box to indicate you have attached an invoice.

• **Environmental Modification**

- Indicate Yes/No if this payment is related to an Environmental Modification (EMOD) service.
- If Yes, choose if this is the first installment, second installment, or job completed.

• **Desired Method of Payment**

- Indicate how you would like the requested funds to be paid:
 - Money Network Card: Funds to be deposited into the EOR's Money Network Card. The EOR makes the payment to the vendor.
 - Direct Deposit: Payment to be deposited to the selected and approved vendor.
 - Palco Paper Check: Payment to be sent to the EOR as a check made out to the vendor. The EOR makes the payment to the vendor.



- **Special Instructions**

- May be used by the EOR to add more information regarding this request (example: CCSC call reference number).

- **Signature / Date**

- Employer of Record (EOR) legal signature and date.

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