MFP Vendor Payment Request

☐ **MFP Services – OR –** ☐ **MFP CBAY Services Rendered for:**

Participant Name:	**Participant/Contact Phone:**
Participant Address:	**Participant City /Zip /County**

MFP Field Personnel Complete:	
Participant Medicaid ID#:	**Participant Date of Birth:**
Discharge Date:	**Anticipated MFP End Date:**

PAYMENT INSTRUCTION

Vendor Name:	**Vendor Phone:**
MAIL CHECK TO (if different):	**Vendor Tax ID, FEIN or SS#:**
Vendor Address:	**Vendor City/State/Zip**

DESCRIPTION OF MFP TRANSITION SERVICES

Description of Services	**Billed Amount**
Total Check Amount	

By signing this form, I attest that services were delivered/received consistent with the transition/ services plan (i.e. ITP, ISP) and *MFP Authorization for Services*. I understand that Medicaid is the payer of last resort.

_____

Signature **Relationship (Participant, Parent/Legal Guardian)** **Date**

_____

Vendor Signature **Date**

Fax or mail to MFP Field Personnel (Print Name): _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Vendor note: send completed form (signed by participant or parent/legal guardian), along with invoice and receipts to MFP field personnel listed above by fax, mail or via file transfer protocol (FTP).
MFP Field Personnel: once verified, send this completed form along with invoice and receipts to the FI by **FTP** and send completed form and required documentation to the appropriate coordinating agency by FTP.