



# MFP Vendor Payment Request



## MFP Services Rendered for:

<b>Participant Name:</b>	<b>Participant/Contact Phone:</b>
<b>Participant Address:</b>	<b>Participant City /Zip /County</b>

<b>MFP Field Personnel Complete:</b>	
<b>Participant Medicaid ID#:</b>	<b>Participant Date of Birth:</b>
<b>Discharge Date:</b>	<b>Anticipated MFP End Date:</b>

## PAYMENT INSTRUCTION

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

## DESCRIPTION OF MFP TRANSITION SERVICES

Description of Services	Billed Amount
<b>Total Check Amount</b>	

By signing this form, I attest that services were delivered/received consistent with the Individualized Transition Plans (ITPs) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

\_\_\_\_\_  
**MFP Participant Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Vendor Signature**

\_\_\_\_\_  
**Date**

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Vendor note:** send this completed form, signed by participant (or 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 note:** once verified, send this completed form along with invoice and receipts to the Fiscal Intermediary by **FTP**. Send this completed form and required documentation to the DCH MFP office by **FTP**.