



MFP Vendor Payment Request

MFP Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City/State/Zip

MFP Facilitator Use Only	
Participant/Member Medicaid #:	Participant/Member Date of Birth:
Date of Transition (Discharge Date):	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 and received consistent with the Individual Transition Plan (ITP) or Person Centered Description (PCD) 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 Facilitator Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Note to Vendor: send this completed form, signed by participant (or legal guardian), along with invoice and receipts to MFP Facilitator listed above by fax, mail or via file transfer protocol.

Note to MFP Facilitator: once verified, send this completed form along with invoice and receipts to the Fiscal Intermediary by **File Transfer Protocol**. Send this completed form and required documentation to the DCH/MFP office by **File Transfer Protocol**.