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:	

PAYMENT INFORMATION				
Date of Service	Procedure Code	Service Description & Explanation	Amount (Including all taxes)	Invoice Attached*
			$	☐

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

Is this a correction to a PRIOR VPR? ☐ YES ☐ NO

Is the item being purchased an EMOD?	☐ Yes ☐ No
For Environmental Modifications (EMOD) Only	☐ First Installment ☐ Second Installment ☐ Job Completed

Special instructions:

By signing this form, I attest that the vendor is qualified to render this service. I also attest thatservices 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.

Phone: 1.800.283.4465 Fax: 1.866.302.6787
Email: docprocessing@conduent.com

CONDUENT
P.O. Box 27460
Albuquerque, NM 87125-7460