MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

VENDOR REQUEST FOR PAYMENT

VENDOR USE

VENDOR NAME	INVOICE NUMBER

VENDOR REMIT TO ADDRESS

STATE VENDOR NUMBER	BILLING PERIOD

CONTRACT NAME / SERVICE	CONTRACT NUMBER	AMOUNT REQUESTED
Child Care Health Consultation		$

COMMENTS

I CERTIFY THAT THIS REPORT IS TRUE AND THAT ALL PAYMENTS CLAIMED ARE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE CONTRACT.

AUTHORIZED SIGNATURE	TITLE	DATE
▶		

FOR DHSS PROGRAM USE ONLY

PURCHASE ORDER (SC, SCS DOCUMENT NUMBER)	RECEIVER DOCUMENT (RC) NUMBER

PROGRAM / BUREAU APPROVAL SIGNATURE(S)	TITLE	DATE APPROVED

COMMENTS

ACCOUNTING DISTRIBUTION

SC, SCS ACCOUNTING LINE NO.	AMOUNT	PLEASE CIRCLE ONE PARTIAL (P) FINAL (F)
		P F
		P F
		P F
		P F
		P F
APPROVED PAYMENT AMOUNT		

DATE STAMP, ETC.

ACCOUNTS PAYABLE SIGNATURE	DATE PROCESSED
▶	