Reimbursement/Vendor Payment REQUEST FORM

This form is for families in the Katie Beckett program. Families can pick from different services that fit their child's budget. The budget is part of it, but these also need to be an approved part of their child's PCSP. These services include getting help with paying for insurance for your child, having a special savings account for health care, and getting money back for services that your child needs. Families can choose one or more of these services. To stay within your budget, submit forms once a month with supporting documentation when you can.

Form Guide

CONSUMER DIRECT CARE NETWORK

REIMBURSEMENT/VENDOR PAYMENT REQUEST FORM

Member Name	CDTN Member ID #

Must include the Child's name

Must include the Child's ID #

Mail/Drop Off: 2 Vantage Way
Suite 250
Nashville, TN 37228

Email: infoCDTN@consumerdirectcare.com

Fax: 1-888-234-1996

Submit reimbursements/vendor payments requests by 5:00 pm CST Monday. Consumer Direct Care Network Tennessee (CDTN) normally makes the payment by the end of the same week.

For Internal Use Only
- ☐ Member Name & ID
- ☐ W-9 – *if needed*
- ☐ Vendor Name & Address
- ☐ Serv. Code Matches Auth
- ☐ Amount approved
- ☐ Item/Service Authorized
- ☐ Funds available

- *The payer must authorize CDTN to make payment for all goods and services.*
- *The Member must have approval for the service amount.*
- *Include all receipts and/or invoices with this form.*
- *CDTN may send this form back for needed corrections. This may result in delay of payment.*

Individual/Vendor name must be the same every month

Issue Payment to
Individual/Vendor Name:
Address:
City/State/Zip:

The vendor must submit a W-9. The Member/Employer of Record does not need to complete a W-9 for premium/community transportation reimbursements.

Any date within the month that the payment is for. Reference paycheck stub

Brief description of what the payout is for. For example: July 2023 Health Insurance

Date of Invoice	Type – *Check one*	Description of Service	Total Dollar Amount
	☐ Vendor Payment ☐ Premium Reimbursement ☐ Community Transportation Reimbursement		

Amount Requested

Please attach a copy of the voided receipt for the service provided from the vendor.

Sign, print, and date the document

I approve CDTN to make payment to the person/vendor named above. I confirm the information above is accurate. I know making intentional false statements is considered fraud. This may result in dismissal from the program and/or criminal prosecution.

_____ _____ _____/____/_____
Member/Employer of Record Signature Print Name Date (mm/dd/yyyy)

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