CONSUMER DIRECT CARE NETWORK

# CAC/SW and SDWP
# COMMUNITY TRANSPORTATION PAYMENT REQUEST FORM

| | | |
|---|---|---|
| | | |
| **Member Name** | **CDTN Member ID #** | **Program Name** |

**Mail/Drop Off:** 44 Vantage Way
Suite 310
Nashville, TN 37228

**Email:**
infoCDTN@consumerdirectcare.com

**Fax:** 1-800-234-1996

Submit Community Transportation payment 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
☐ 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.*
- *If funds are deposited to my account in error, or an improper payment is made, I authorize CDTN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDTN may withhold future payments until the erroneous deposited amounts are repaid.*

| Date of Service | Description of Transportation | Total Dollar Amount |
|---|---|---|
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***Please attach a copy of the voided receipt for the service provided from the vendor if applicable.***

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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