

# 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



### REIMBURSEMENT/VENDOR PAYMENT REQUEST FORM

<b>Member Name</b>	<b>CDTN Member ID #</b>
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**Mail/Drop Off:** 44 Vantage Way  
Suite 310  
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.

**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.

Date of Invoice	Type – Check one	Description of Service	Total Dollar Amount
	<input type="checkbox"/> Vendor Payment		
	<input type="checkbox"/> Premium Reimbursement		
	<input type="checkbox"/> Community Transportation Reimbursement		

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

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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Must include the Child's name

Must include the Child's ID #

Individual/Vendor name must be the same every month

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

Amount Requested

Sign, print, and date the document