CDCS Payment Request
Request for Reimbursement or Payment

Program # _____

Services/Purchase made in which month/year? _____

Date of service or purchase:		Description:		Amount:	
Date of service or purchase:		Description:		Amount:	
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Date of service or purchase:		Description:		Amount:	

Check payable to: _____

Total:
To update total click on cell to right and press F9. _____

☐ Mail check to Payee (payee address is on file already or listed on supporting documentation)
☐ Check here if address of payee is not the address listed on Invoice (complete address information below)
☐ Check here if new payee address

Street: _____

City: _____ State: _____ Zip: _____

Managing Party Signature: _____ **Date:** _____

For Dungarvin Use Only:

To be Charged to:

MODIFIER	COST CATEGORY	AMOUNT	UNIT RATE	UNIT #	REPORT LANGUAGE	DOC #

Documentation:

_____ Original Bill/Invoice/Statement/Receipt attached
_____ Other (explain): _____

Routing Instructions:

_____ Mail Payment Directly to Payee
_____ Send Check to: _____

Special Instructions:

☐ Please include copy of invoice with check
☐ Other _____

Dungarvin Representative: _____ Date: _____