

Request for Vendor Payment



Participant Name	Participant Acumen ID #
Employer Name	Month/Year

Payment Instructions

Make Check Payable To:	
Vendor FEIN or SS#	Vendor Name
Vendor Address	Vendor City/State/Zip

Therapy Services (except Swallowing & Feeding Eval) and Behavioral Support Services can be performed via Telehealth.

Check this box if this request is for a service that was provided via telehealth. ☐

Invoice/ Service Date	Service Code	Description	Total Amount
		Total Check Amount	
		Invoice Number	

FOR LYFT USERS ONLY

Invoice/Service Date	Service Code	Description	Amount
		Total Lyft Amount Requested	

Usage Type: ☐ Monthly ☐ One-Time Funds Outside of Lyft: ☐ Yes ☐ No

Phone Number/Email linked to Lyft account that will be using funds: _____

If yes, anticipated amount outside of Lyft (monthly): \$ _____

REMINDER: Please attach a copy of the voided receipt or invoice. Return completed form to Acumen by emailing to vendor-ga@acumen2.net or by mailing to 5416 E Baseline Rd., Suite 200, Mesa, AZ 85206 or by faxing to (877) 522-8636.

By signing this form, I attest that services were delivered and received consistent with the Individual Service Plan, and I have rendered and/or approved this payment request in accordance with the Program regulations. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized, including but not limited to my repayment of claim.

Participant or Representative's Signature _____

Date _____