



STATE OF NEW JERSEY
PAYMENT VOUCHER

(VENDOR INVOICE)

PO#

PV

DOCUMENT

BATCH

ACTG. FY
PER.

TC AGY NUMBER TC AGY NUMBER

PP START SCHED PAY CHK OFF F RF CK (A) VENDOR
MO DY YR MO DY YR CAT LIAB A TY FL ID NUMBER

Table with columns: CONTRACT NO, AGENCY REF, BUYER, (B) TERMS, PAYEE: SEE INSTRUCTIONS FOR COMPLETING ITEMS (A) THROUGH (G), (C) TOTAL AMOUNT \$ 0.00

(D) PAYEE NAME AND ADDRESS

Provider Agency name & address

(E) SEND COMPLETED FORM TO:

DDD.MediElighelpdesk@dhs.state.nj.us

Provider Agency signature

(F) PAYEE DECLARATIONS

I CERTIFY THAT THE WITHIN PAYMENT VOUCHER IS CORRECT IN ALL ITS PARTICULARS, THAT THE DESCRIBED GOODS OR SERVICES HAVE BEEN FURNISHED OR RENDERED AND THAT NO BONUS HAS BEEN GIVEN OR RECEIVED ON ACCOUNT OF SAID DOCUMENT.

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PAYEE SIGNATURE

PAYEE TITLE

BILLING DATE

Table with columns: LINE NO, REFERENCE (CD, AGY, NUMBER), LINE, (G) PAYEE REFERENCE

Table with columns: FUND, AGCY, ORG CODE, SUB-ORG, APPR UNIT, ACTIVITY CD, OBJECT CD, SUB-OBJ, REV SRCE, SUB-REV, PROJECT/JOB NO

Table with columns: RPT CT, BS ACT, DT, DESCRIPTION, QUANTITY, AMOUNT, ID, PF, TX

Table with columns: ITEM NO., COMMODITY CODE/DESCRIPTION OF ITEM, QUANTITY, UNIT, UNIT PRICE, AMOUNT. Includes handwritten entries: DDD ID, Waiver Service, Procedure Code, i.e.: 15 min, # of Units, daily, Unit Rate, Dates Requesting Payment, TOTAL \$ 0.00

CERTIFICATION BY RECEIVING AGENCY: I certify that the above articles have been received as stated herein. DDD Signature, Signature, Title, Date

CERTIFICATION BY APPROVAL OFFICER: I certify that this Payment Voucher is correct and DDD Signature, Authorized Signature, Title, Date

PAYEE INSTRUCTIONS

ITEMS **A** THROUGH **G** ARE TO BE COMPLETED BY PAYEE

A VENDOR IDENTIFICATION NUMBER

Complete the payee identification field with the federal employer identification number assigned to the business or the social security number if the payee is an individual.

B TERMS

The terms of sale, such as "net," "2% fifteen days," etc.

C TOTAL AMOUNT

Enter the total amount of this payment voucher.

D PAYEE NAME AND ADDRESS

The name of the individual or company to whose name the check shall be drawn and the complete address where the check shall be mailed.

E SEND COMPLETED FORM TO:

DDD.MediElighelpdesk@dhs.state.nj.us

F PAYEE DECLARATION

Payee must sign the declaration and date the payment voucher is prepared.

G PAYEE REFERENCE NUMBER

Payee must show his **own** invoice or billing number or any other identification for reference purposes. **This information is recorded on the check stub and aids the payee to identify the invoices which have been paid.** Do not use more than 30 characters.

PAYEE IS TO COMPLETE THE SCHEDULE OF ITEMS OR SERVICES SHOWING QUANTITY, UNIT, DESCRIPTION, UNIT PRICE AND AMOUNT. IF THE NUMBER OF ITEMS EXCEEDS THE SPACE, ATTACH A SCHEDULE SHOWING THE REQUIRED INFORMATION.

TO INSURE PROMPT PAYMENT, SEND COMPLETED PAYMENT/VOUCHER TO THE DEPARTMENT/AGENCY SHOWN IN **E** ITEM

VENDORS MAY BE ENTITLED TO INTEREST ON PAYMENT VOUCHERS IF PAYMENT IS NOT MADE WITHIN 60 DAYS OF THE DATE OF ACCEPTANCE OF A PROPERLY EXECUTED PAYMENT VOUCHER OR RECEIPT OF GOODS OR SERVICES, WHICHEVER IS LATER. **INQUIRIES SHOULD BE MADE DIRECTLY TO THE DEPARTMENT OR AGENCY SHOWN IN **E** ITEM**