THIRD PARTY REQUEST FOR PAYMENT FORM

- Use this form only when an invoice is not available. Include all supporting documentation with this request for payment.

Issue payment to: ______________________________

Address at which to remit payment:

____
STREET ADDRESS CITY STATE ZIPCODE

Federal Tax ID # or Social Security #: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Note: This is required only if the vendor qualifies as an Independent Contractor per the terms listed in the Emory Healthcare Accounts Payable Policy and Procedures Manual for Operating Units.

Accounts Payable Policy and Procedure Manual is located on the VDT Intranet.

Disposition Instructions (check one): ☐ Mail via the U.S. mail ☐ Mail via the U.S. mail with enclosures

Date	Department #	Description of Expenditure	Account #	Amount
				$
				$
				$
				$
				$
				$
				$
			Grand Total	$

Payment description to print on check: ______________________________
20 character maximum

Special instructions to accounts payable: ______________________________

____

____
AUTHORIZED APPROVER'S SIGNATURE

______________________________ ______________________________
DATE PHONE EXTENSION