VENDOR INVOICE FOR GOODS OR SERVICES
RENDERED TO THE STATE OF CONNECTICUT
CO-17 Rev 7/13
VENDOR: Please complete this form and send it to the DEPARTMENT **BILLING ADDRESS** SHOWN ON PURCHASE ORDER

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
ACCOUNTS PAYABLE DIVISION

(1) Business Unit Name	(2) Business Unit Number	(3) Invoice Number		(4) Invoice Amount
DPH		TB		$
(5) Document Date	(6) Invoice Date	(7) Accounting Date	(8) Rpt. Type	(9) . VENDOR FEIN/SSN - SUFFIX

VENDOR/PAYEE: FIELDS 8, 9, 10, 14 and 18 ARE MANDATORY FOR PAYMENT

(10)
Payee:
Address:
Address:
City: **State:** **Zip:**

(11) Voucher Number

(12) Voucher Date:

Prepared by:

(13) VENDOR BILLING COMMENTS:

(14) Give a full description of goods or services	(15) Quantity	(16) Units	(17) Unit Price	(18) Amount
Services in connection with the Tuberculosis Control Program in accordance with Conn. Gen. Stat. § 19a-255 as follows:				
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
	________	________	________	$ __________
				Total: ____________

I hereby certify that (1) this is a valid claim for the treatment and care of tuberculosis; (2) said claim has not been paid; (3) all efforts have been made to obtain payment for said services from all potential third-party payers; (4) no outstanding requests for payment for said services are currently pending with the patient or third-party; (5) I will not submit a billing request for said services to the patient or any third-party after the date hereof; and (6) if I receive payment for said service from anyone other than the State, I will promptly contact the Department of Public Health and comply with its reimbursement instructions.

XX ____
Signature of Authorized Person

____
(Print or Type Name & Title)

BUSINESS UNIT USE ONLY

(19) Amount	(23) FUND	(24) Department	(25) SID	(26) Program	(27) Account	(28) Project	(29) Budget Ref	(30) CFDA #
	12004	DPH48666	16112	42003		DPH16112XRYSCRN		

(31) **DEPARTMENT NAME AND ADDRESS:**

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
410 CAPITOL AVENUE, MS# 11TUB
PO BOX 340308
HARTFORD, CT. 06134-0308

(32) PO NO.

(35) COMMODITIES RECEIVED or SERVICES RENDERED- Signature

____
(DPH AUTHORIZED SIGNATURE)

(34) PO BUS UNIT

(36) Receiving Report No.

(37) Date of Receipt

SHIPPING INFORMATION

(38) Date shipped	(39) From City/State	(40) Via Carrier	(41) F.O.B.