VENDOR INVOICE FOR GOODS OR SERVICES RENDERED TO THE STATE OF CONNECTICUT

CO-17 Rev 12/22

Please complete this form and FAX it to **860-730-8271**, or mail it to the DEPARTMENT **BILLING ADDRESS** SHOWN BELOW.

STATE OF CONNECTICUT OFFICE OF THE STATE COMPTROLLER ACCOUNTS PAYABLE DIVISION

(1) Business Unit Name	DPH	(2) Business Unit N	umber	(3) Invoice I TB				4) Invoice Amount \$			
(5) Document Date		(6) Invoice Date			accounting Date		pt. Type	(9) . VENDOR FEIN/SSN - SUFFIX			
VENDOR/PAYEE: FIELDS 8, 9, 10, 14 and 18 ARE MANDATORY FOR PAYMENT											
(10) Payee: Address:						(11) Voucher Number					
Address:							(12)				
City: State: Zip:							Voucher Date:				
οιιγ. οιαι ς . ΖΙμ.							Prepared by:				
(13) VENDOR BILLING COMMENTS:											
(1.4)		(15)	1,	(16)	(17)	(18)					
(14) Give a full description of goods or services						Quan		Units	Unit Price	Amount	
Give a full description of goods or services Services in connection with the Tuberculosis Control Program in accordance with Conn. Gen. Stat. § 19a-255 as follows: 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.										\$ \$ \$ \$ \$ \$ \$ \$	
Signature of Authorized Person Total:											
(Print or Type Name & Title)											
BUSINESS UNIT USE ONLY											
(19) Amount	(23) FUND	(24) Department	(25) SID	(26) Program	(27) Accour		28) Project		(29) But	dget Ref CFDA #	
AIIIOUIII	12004	Department DPH48666	16112	42003	Accour	IL		DH16112V		uyetket CFDA#	
(31) DEPARTMENT NAME AND ADDRESS: (32) PO						PH16112XRYSCRN					
` '	DEPARTMENT APITOL BOX 340308 08		_					IZED SIGNATURE) (37) Date of Receipt			
SHIPPING INFORMATION											
(38) Date shipped		(39) From City/S						(4	1) F.O.B.		
, , rr==		, ,	(40) Via Calli					Ι '	•		