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

CO - 17 REV. 12/2025

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
ACCOUNTS PAYABLE DIVISION

VENDOR: PLEASE COMPLETE THIS FORM AND SEND IT TO THE TB PROGRAM VIA FAX TO 860-706-1232 FOR PROCESSING.

(1) BUSINESS UNIT NAME	(2) BUSINESS UNIT NO.	(3) INVOICE NO.(for DPH use ONLY)	(4) INVOICE AMOUNT(for DPH use ONLY)
DPH	DPHM1	TB	$

(5) DOCUMENT DATE (for DPH use ONLY)	(6) INVOICE DATE (for DPH use ONLY)	(7) ACCOUNTING DATE (for DPH use ONLY)	(8) REPORT TYPE*	(9) VENDOR FEIN/SSN ID / ADDRESS CODE*

VENDOR / PAYEE: FIELDS 8-10 and 14-18 ARE MANDATORY FOR PAYMENT (Field 16 is mandatory for Pharmacy only)

(10)
PAYEE:* HOSPITAL - INPATIENT VENDOR
PAYEE:*
ADDRESS:*
ADDRESS:*
ADDRESS:*
CITY:* STATE:* COUNTRY:* ZIP CODE:*

(11) VOUCHER NO. (For DPH use ONLY)

(12) VOUCHER DATE (For DPH use ONLY)

PREPARED BY

(13) VENDOR COMMENTS

(14) GIVE FULL DESCRIPTION OF GOODS AND / OR SERVICES* (TO BE COMPLETED BY VENDOR - SEE INSTRUCTIONS)	(15) QUANTITY*	(16) UNITS*	(17) UNIT PRICE*	(18) AMOUNT*
Dates of Service: Jan. 1, 2025 - Jan. 23, 2025				
Number of Days: 22				
INPATIENT	22			
-	-	-	-	**Total:**

SAMPLE

BUSINESS UNIT USE ONLY

(19) AMOUNT	(20) QUANTITY	(21) FUND	(22) DEPARTMENT	(23) SID	(24) PROGRAM	(25) ACCOUNT	(26) PROJECT/ GRANT	(27) CHARTFIELD 1	(28) CHARTFIELD 2	(29) BUDGET REFERENCE
	N/A	12004	DPH48666	16112	42010		DPH16112XRYSCRN	N/A	N/A	N/A

(30) DEPARTMENT NAME AND ADDRESS

State of Connecticut Department of Public Health
TB Billing Program
Fax #: 860-706-1232

(31) PO NO.

(32) COMMODITIES RECEIVED OR SERVICES RENDERED - SIGNATURE

(33) PO BUSINESS UNIT

(34) RECEIVING REPORT NO.

(35) DATE(S) OF RECEIPT(S)

SHIPPING INFORMATION

(36) DATE SHIPPED	(37) FROM - CITY / STATE	(38) VIA - CARRIER	(39) F.O.B.