**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:* LABORATORY 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 | | | | |
| LABS | -- | | -- | |
| - | - | - | - | **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 |
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(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. |
|---|---|---|---|
| | | | |