Reset Form

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	(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
			Select >>	

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

(10)
Payee: **LOCAL HEALTH VENDOR**
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:				
Dates of Service: Jan. 1, 2025 - Jan 23, 2025				
*** Field Visit**	1		66.00	$ 66.00
*** DOT**	5		66.00	$ 330.00
*** eDOT**	10		20.50	$ 205.00
*** PPD Test**	1		4.50	$ 4.50
				$
				$
				$
				$
				Total: **$605.50**

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
Signature of Authorized Person

Name & Title Printed
(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
FAX Number: **860-730-8271**

(32) PO NO.

(34) PO BUS UNIT

(35) COMMODITIES RECEIVED or SERVICES RENDERED- Signature
(DPH AUTHORIZED SIGNATURE)

(36) Receiving Report No.

(37) Date of Receipt

SHIPPING INFORMATION

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

Print Form