FOUNDATION HEALTH PARTNERS

# CHECK REQUEST

**Do Not Write In This Space – For Finance Use Only.**

**Vendor #:** _____ **PO#:** _____

**Payable To:** _____

| | |
|---|---|
| Address | |
| Address | |
| City | |
| State/Zip | |

| **Check Disposition:** | |
|---|---|
| | Mail to Listed Address |
| | Pick-up in Accounts |
| **Department: | |

| | |
|---|---|
| **Amount:** | |
| **Cost Center:** | |
| **Expense Code:** | |

| **Description:** |
|---|
| |

**DISBURSEMENT CERTIFICATION**

I/We certify that this disbursement or expenditure(s) is/are true and correct and that the requested supporting documentation is attached

| | | |
|---|---|---|
| **Date:** | | **Requested by:** |

| | | |
|---|---|---|
| **Date:** | | **Approved by: (Supervisor)** |

**MANUAL CHECK AUTHORIZATION**

Please note additional authorization is needed from your administrative representative prior to requesting a manual check.

| | |
|---|---|
| **Date:** | **Administrator Approval:** |

**** If marked for Pick-up the Department line must be filled in. The Department Manager will be notified once it is available for pick-up** Please note if the check disposition is not marked the default is to mail the check****