

VENDOR PAYMENT REQUEST

(includes bills from doctors for expert fees, depositions, medical review and consultation, court reporters, investigators, mediators, life planners and copy charges (\$500 and over per entry)

Case Name _____ v. _____
Plaintiff Defendant(s) you are representing

Invoice # _____ Date of invoice _____

Type of Service: _____
(Ex. Court reporter, expert service, mediation, copy charge, etc.

Vendor Name _____ TIN or SSN: _____
Note: If you have not used this vendor in this case, you must provide a W-9 with billing Vendor name must match with TIN or SSN on file with IRS

Vendor Address _____
(Must match address on W-9; this is where check will be mailed)

Date(s) of service _____
(Ex. Date of mediation, surveillance or deposition, name of deponent, date of expert service)

Special Instructions:

Your billing contact information: Name _____

Phone _____ Fax _____ Email _____

For HCSF Use Only: (Authorized by: _____) (Date: _____)

Total Amount Requested: \$ _____ Case No: _____ Case Letter: _____

\$ _____ () \$ _____ () \$ _____ () \$ _____ ()

___ **KU Foundation** ___ **KU Residency** ___ **WCGME** ___ **GMED**