Centra Health

Accounts Payable Check Request

Date of request: _____

Date check needed: _____

Contact Name: _____

Contact Dept: _____

Notice

All forms should be emailed to AP.Invoices@Centrahealth.com with supporting documentation. Please allow 7-10 days for processing.

Payable to:

Address:

Mail check to the above address: ☐ Yes ☐ No

If No is indicated: ☐ ACH ☐ Pick up ☐ Send to Contact Dept

Purpose of check:

Account Distribution CO-DEPT-ACCT	Line Description or Contract #	Amount to be Paid
	Total	$ -

_____ _____

Requested by Date

_____ _____

Approved by Date

Note: DO NOT use this form for employee reimbursement. This purpose of this form is to request payment for expenses that do not require a PO or if an invoice is unavailable from the vendor. If you have a vendor invoice, please code and approve directly on the invoice and submit it to AP. Please do not include this form when submitting a vendor invoice.