WRIGHT COUNTY
HEALTH & HUMAN SERVICES

CLAIM FOR PAYMENT

Wright County Health &Human Services
1004 Commercial Drive
Buffalo, MN 55313-1736

PLEASE ISSUE CHECK PAYMENT TO

(Name of the Person or Firm making the Claim)

(Mailing Address)

(City) (State) (Zip Code)

FID # 41-1268614

Service Dates	Description of Merchandise or Service Rendered	Amount
to		
to		
to		
to		
to		
to		
to		
to		
to		
to		
to		
(*Note: Original signature and receipts must accompany claim.*) Add Mileage Page	**TOTAL**	**$ 0.00**

I declare under penalties of law that this account, claim, or demand is just and correct and that no part of said claim has been paid.

Claimant Name

Signature of Claimant

Title or Position

Phone Number

Name of Firm or Organization

Email Address

The effect of this verification shall be the same as if subscribed and sworn to under oath. MN Statute 471.38.

AGENCY USE ONLY

Vendor Number _____ Approved By: _____

ACCOUNT # OR FORMULA					AMOUNT	INVOICE NUMBER/ DESCRIPTIONS	SERVICE DATES	
							FROM MM/DD/YY	TO MM/DD/YY
				TOTAL	$ 0.00			

ISSUANCE DATE **WARRANT #**