County Of San Bernardino
Department of Behavioral Health

OUTSIDE VENDOR SERVICE REQUEST FORM

Staff Name:_____ Date Requested:_____

Program/Clinic Name: _____

Date services are needed: _____

Language requested (Including sign language): _____

Consumer Name: _____ Chart Number: _____

TO BE COMPLETED BY SUPERVISOR

Justification for service:

_____

_____

_____

_____

☐ *Approved* ☐ *Denied*

*Date*_____ *Supervisor's Name:*_____

CONTRACT VENDOR INVOICE

Contract Vendor Name:_____ Access Code:_____

Service Date:_____ Charged Time:_____ Service Cost:_____

Provider's name_____ Date:_____

Signature:_____