



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 WIC AND NUTRITION SERVICES  
**APPROVAL REQUEST FOR NON-PAID WIC CHECKS**

**STAMP WIC VENDOR NUMBER  
 HERE.**

**All fields must be completed or check appeal will be denied.**

DATE MAILED: ____ / ____ / ____	CHECK NUMBER: _____
RETAILER NAME:	
RETAILER ADDRESS:	
CONTACT NAME:	
CONTACT TELEPHONE: _____ - _____ - _____	

<b>ATTACH RECEIPT HERE</b>	JUSTIFICATION:

<b>ATTACH CHECK HERE</b>	<b>Mail completed form, check, copy of invoice, and matching register receipt to:</b>
	Missouri Department of Health and Senior Services WIC and Nutrition Services P.O. Box 570 Jefferson City, MO 65102-0570

**This institution is an equal opportunity provider.**