COVENANT HEALTH SYSTEM VENDOR APPLICATION

VENDOR REMIT INFORMATION

Legal name as shown on your income tax return:					
Name on invoices:				SSN / EIN :	
Remit address:					
City:		State:		ZIP Code:	80203

The Vendor above is ☐ an individual, partnership, or LLC ☐ a Corporation other than LLC ☐ a US, State or Local Government ☐ Other

Contact at Covenant Health or subsidiary: Nicole Taylor

PAYMENT TERMS – TO BE COMPLETED BY ACCOUNTS RECEIVABLE

Accounts Receivable (AR) Contact:		Phone Number:	
☐Purchasing Card – Net 30	AR email for Credit Card remittance advice:		

☐Check – Net 45 All checks are processed on a Net 45 basis unless discount is offered via terms on invoice or per signed contract.

☐Terms as outlined per signed contract on file with Covenant Corporate Materials Management. **Terms will default to Check-Net 45 if no Contract has been filed with Covenant Corporate Materials Management.** Terms:

☐Discount offered for payment by check for terms other than Net 45 (be sure to include terms on your invoices) Terms:

PURCHASING INFORMATION

Physical Address:	☐Same as listed above				
City:		State:		ZIP Code:	
Contact Name:				Title:	
Phone:		E-mail:		Fax:	
EDI Options:					

SUBSTITUTE W-9

Under penalties of perjury, I certify that:
(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) **AND**
(2) I am not subject to backup withholding because ☐ I am exempt from backup withholding, or ☐ I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, or ☐ the IRS has notified me that I am no longer subject to backup withholding **AND**
(3) I am a US person (including a US resident alien). **OR** ☐I have been notified by the IRS that I am currently subject to backup withholding.

COMPLIANCE STATEMENTS AND QUESTIONS

Covenant Health's policy regarding the Deficit Reduction Act (DRA) and our Vendor Terms and Conditions (Vendor Agreement) are available through the Vendor page on our web site at: http://www.covenanthealth.com/?id=38&sid=1 . Vendor is required to abide by the Covenant Health Terms and Conditions as to the work performed for Covenant Health or for any Covenant Health affiliate/subsidiary.

(1) Are you an MD, DO, DDS, DMD, DPM, OD, or chiropractor? ☐Yes ☐No
(2) Are you an "immediate family member" of any of the above? ☐Yes ☐No
(3) Are you a business owned in whole or in part by an MD, DO, DDS, DMD, DPM, OD, or chiropractor, or by an "immediate family member" of the same? ☐Yes ☐No

"Immediate family member" means a spouse, birth/adoptive parent, child, sibling, stepparent, stepchild, stepsibling, parent-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or the spouse of any of the foregoing.

If you have answered "Yes" to any of the above questions do not provide supplies or services without a written agreement that has received proper Covenant Health approvals. Please provide the name and business location of the MD, DO, DDS, DMD, DPM, OD, or chiropractor(s):

_____

(4) I certify that there are no known Conflicts Of Interest as outlined in the Vendor Agreement. ☐Yes ☐No

The person signing below must be authorized to sign on behalf of the Vendor whose SS# or EIN is listed on this Application. By signing below, Vendor represents and warrants that the information provided in this Application is accurate and complete; agrees to provide prompt written notice of any material change to such information via the fax number/e-mail address listed below; and agrees to abide by the Vendor Terms and Conditions, available at http://www.covenanthealth.com/?id=38&SID=1 and incorporated herin by reference, as to the work performed for Covenant Health or for any Covenant Health affiliate/subsidiary.

Authorized Signature:			
Printed Name:			
Title:		Date:	

FAX to: 865-374-6880 EMAIL to: vendormastermailbox@covhlth.com with the name on your invoices in the subject line