New Vendor Form (*Please Print)*

Vendor Number:

Name _____

Name/Address _____

Address _____

City _____ State _____ Zip _____

Remittance Address (If different)

Name _____

Address _____

City _____ State _____ Zip _____

Account Number (If Applicable) _____

Federal ID # (SSN or EIN) _____ Payment Terms _____

Contact Name Phone # Fax #

1099 Vendor

1. Is the vendor selling merchandise to RMCHCS?

____ Yes. Stop. **A 1099 is not required**. Do not answer the remaining questions

____ No. Proceed to question #2

2. Is this vendor a corporation?

____ Yes. Proceed to question #3.

____ No. Skip question #3 and proceed to question #4.

3. Is RMCHCS making medial care payments (physicians, nurses, or other supplier/provider of medical care service) , or making a payment to an attorney?

____ Yes. Stop. **A 1099 is required**. Get a completed W-9 from the vendor.

____ No. Stop. A 1009 is not required . Do not answer question #4.

4. Is this vendor an employee being reimbursed for business expenses for travel, supplies, etc.?

____ Yes. A 1099 is not required.

____ No. **A 1099 is required**. Get a completed W-9 from the vendor. Describe what RMCHCS is paying for (i.e. rent, services, etc...) _____

Reason for adding new vendor: _____

Must attach HHS/OIG Cumulative Sanction Report before approval (http://exclusions.oig.hhs.gov/)

Existing Vendor Update *(Please Print)*

Vendor Number:

Name _____

Name/Address _____

Address _____

City _____ State _____ Zip _____

Federal ID # (SSN or EIN) Payment Terms

This form must be completed in it's entirety before approval will be granted for new vendor.

Requested By _____ Date Phone

Finance Approval _____ Date Phone