

## VENDOR DATA SHEET

1. **Company Name:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Toll Free #** \_\_\_\_\_ **Fax #** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip + Four:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Agency Website:** \_\_\_\_\_

**Federal ID# or SSN:** \_\_\_\_\_ **Medicare #** \_\_\_\_\_ **Medicaid#** \_\_\_\_\_

**For Profit:**  **or Non-Profit**  **Tax Exempt: Yes**  **No**  **Agency NPI #** \_\_\_\_\_

**Check Appropriate Box: Individual / Sole Proprietor**  **Corporation**  **Partnership**

**Limited Liability Company**

2. **Contract Administrator (Name that will appear on the contract)**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip + Four:** \_\_\_\_\_

3. **Contact Person For Billing Questions**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip + Four:** \_\_\_\_\_

4. **Company Name and Address to Send Payments To**

**Agency Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip + Four:** \_\_\_\_\_

5. **Contact Person For Program Related Matters**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip + Four:** \_\_\_\_\_