Date	New Vendor ☐	Request changes ☐

The form must be completed to add or make changes to the vendor profile. Please submit the form and the required documents to vendoradmin@americanchoicehealthcare.com and allow two weeks to review and update our records.

Company Legal Name (as shown on Federal Tax return) **Copy of latest W9 Required**

Alternate name (DBA), if applicable (doing business as):

TAX ID (EIN or SS #) (**Required**)

ORGANIZATION TYPE (Please select as shown on W9)	
Corporation LLC ☐	Partnership ☐
S Corporation ☐ Other ☐	Individual/Sole Proprietorship ☐
Main address	Billing/Mailing address (if different)
Street:	Street:
City:	City:
State & zip code:	State & zip code:

Company website:

Email address for payment remittances: (**required**)

Supplier type: Landlord ☐ Supplier goods/services ☐ Utilities ☐ Attorney ☐ Insurance ☐ Providers ☐

Contact Information

Name and Title:

Phone number:

Email address:

Standard payment terms: N30 ☐ N60 ☐ N90 ☐ days from invoice date

Other ☐, specify _________ (Different terms must provide copy of a signed agreement to your American Choice Healthcare representative.

Payment method: ACH only ☒

Please complete ACH details:

Personal checking ☐ Bank **Bank letter or copy of a voided check required**	Business checking ☐ **Bank entity letter with ACH details required**
Bank name:	Name on the account:
Account #:	ABA/Routing number for ACH:

(Initials) ________ I certify that the above information is true and correct; and that as a legal representative for the above-named company, I hereby authorize American Choice Healthcare to electronically deposit payments to the designated bank account. This authority remains in force until American Choice Healthcare A/P Department, receives written notification requesting a change or cancellation to vendoradmin@americanchoicehealthcare.com

Vendor's Signature / Title

American Choice Healthcare representative name / Title