Provider Vendor Form

Date: _____ **New Vendor** ☐ Or **Requesting Changes** ☐

The form must be completed to add or make changes to the vendor profile. Please submit the form with the required documents to vendoradmin@canohealth.com and allow two weeks to review and update our records. ***Current W9 is required***.

Company Legal Name (*as shown on Federal Tax return*):

Alternate name (*Business Name or DBA*), if applicable:

Tax ID (*EIN or SS#*) (***Required***):

Organization Type (*Please select as shown on W9 – Check only one*)

Corporation ☐ S Corporation ☐	LLC ☐ Other ☐	Partnership ☐ Individual/Sole Proprietorship ☐

Main Address	**Billing/Remittance Address**
Street: City: State & zip code:	Street: City: State & zip code:

Company website:

Email address for Payment Remittances (*Required*):

Email address for Purchase Orders (*Required*):

Supplier Type: Provider ☒

Contact Information (*must be Printed or Typed*)

Name and Title:

Phone number:	Email address:

Standard payment terms: Other, Due Upon Receipt ☒	**Payment method**: ACH only ☒

Please complete ACH details (***Bank letter required for Corporations | Voided check required for Individuals***)

Business checking ☒

Bank name:

Name on the account (***Must match W9***):

Account Number:

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@canohealth.com. Conflict of Interest Disclaimer: Every employee and vendor of American Choice Healthcare has the duty to disclose conflicts, or potential conflicts, to American Choice Healthcare, and to refrain from actions that may conflict with American Choice Healthcare's interests. By signing this agreement, you are acknowledging compliance with American Choice Healthcare's Conflict of Interest policies.

Vendor/Provider's Signature:

Vendor/Provider's Printed Name and Title:

American Choice Healthcare Representative: Michael Labinski, Chief Financial Officer & Vice President of Finance

Sample Bank Letter

WELLS FARGO

Commercial Banking
MAC Z6183-050
1699 Coral Way, 5th Flr
Miami, FL 33145

June 28, 2022

Re: Your Practice Name

Account #: Your Practice Bank Account #

ABA/Routing # for ACH: Your Practice ABA #

To Whom It May Concern:

May this letter serve as confirmation that the above referenced account is maintained at Wells Fargo Bank.

Incoming wire instructions are as follows:

RTN/ABA: Your Practice ABA #

Bank name Wells Fargo Bank, N.A.

Bank address, 420 Montgomery, San Francisco , CA , 94104

Beneficiary acct: Your Practice Account #

Beneficiary: Your Practice Name

Inter. Wires: Your Practice SWIFT Code#

Should you need additional verification please contact me at (786) 555-1234

Sincerely,

Your Bank Representatives Signature

Your Practice Bank Representative
AVP/Business Relationship Support Specialist