



Vendor Information

VENDOR INFORMATION			
Name		FEIN or SS# of Payee	
Mailing Address	City	State	Zip Code
Phone Number	Email		
Pay Type: <input type="checkbox"/> Paper Check <input type="checkbox"/> EFT (If this option is selected, attach a direct deposit authorization agreement)			
<input type="checkbox"/> A W-9 is required for all vendors, a form is attached.			

MEMBER/PARTICIPANT INFORMATION	
Full Name (First, Middle, Last):	Medicaid ID:

Please check the services that your agency will be providing and billing.

TYPE OF AGENCY/VENDOR EXPENSES	
<input type="checkbox"/>	Agency-directed Personal Care Attendant
<input type="checkbox"/>	Employment Support (Follow along)
<input type="checkbox"/>	Meal Service
<input type="checkbox"/>	Emergency Monitoring
<input type="checkbox"/>	Emergency Monitoring Installation
<input type="checkbox"/>	Snow Removal/Mowing
<input type="checkbox"/>	Transportation
<input type="checkbox"/>	Other

Please return this form via email to: mi.via@conduent.com or via fax to 1.866.302.6787.