Vendor Information

VENDOR INFORMATION			
Name		FEIN or SS# of Payee	
Mailing Address	City	State	Zip Code
Phone Number	Email		
Pay Type: ☐ Paper Check ☐ EFT (If this option is selected, attach a direct deposit authorization agreement)			
☐ 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
☐	Agency-directed Personal Care Attendant
☐	Employment Support (Follow along)
☐	Meal Service
☐	Emergency Monitoring
☐	Emergency Monitoring Installation
☐	Snow Removal/Mowing
☐	Transportation
☐	Other

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