



Vendor Information Form

MEMBER INFORMATION	
Full Name (First, Middle, Last):	Medicaid or Palco ID:

VENDOR INFORMATION			
Name	FEIN or SS# of Payee		
Mailing Address	City	State	Zip Code
Contact Person	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; the form is attached.			

Please describe the services that your agency will be providing and billing for:

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