Vendor Setup Packet

Prior to receiving payment, all vendors must submit this setup packet before they can be established in our system. This includes organizations and individuals.

Save time, submit online!
Instead of completing this PDF, you can now submit this information online at alliancehealthplan.org/forms/4.

The Vendor Setup Packet includes:

I. **Vendor Profile:** Required for all vendors.
II. **Electronic Funds Transfer (EFT) Authorization:** Required only for Network Health Care Providers; however, all vendors are encouraged to submit this form to shorten payment processing time. A blank, voided check or bank-generated verification form should also be attached.
III. **IRS Form W-9:** Required for all vendors.

I. Vendor Profile

General information

Both the legal name and TIN should match Alliance Health records.

If the vendor legal name you listed is an individual, generally your taxpayer identification number (TIN) is your social security number (SSN). For other entities, it is your employer identification number (EIN).

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Vendor type (choose one): *

- ◯ General Business Vendor
- ◯ Housing/TCLI Vendor
- ◯ Network Health Care Provider
- ◯ Non-Business Vendor (typically used for reimbursing individuals)

Business structure (choose one): *

- ◯ C-Corp.
- ◯ General Partnership
- ◯ Governmental Agency
- ◯ Individual
- ◯ Limited Partnership
- ◯ LLC
- ◯ LLP
- ◯ PC
- ◯ S-Corp.
- ◯ Sole Proprietorship
- ◯ Other (if applicable) _____

Business type (choose one): * ◯ Profit ◯ Nonprofit ◯ N/A

Legal name * _____ (As registered with the Secretary of State) Doing business as (DBA) _____ (If applicable)

Phone * _____ Fax _____

Website address (URL) _____

Taxpayer identification number (TIN): *

Social security number (SSN) _____ **OR** Employer identification number (EIN) _____

Do you require a 1099? * ◯ Yes ◯ No

Mailing address

2

Address line 1 * _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City * _____ State * _____ Postal code * _____

Contact information

3

Contact name * _____ Title * _____

Email * _____

Authorization

4

I hereby certify that, to the best of my knowledge, the provided information is true and accurate, and I am authorized to submit this form on behalf of the listed organization.

Signature (sign or type)* Date (mm/dd/yyyy) *

x _____ _____

II. Authorization Agreement for Electronic Funds Transfer (EFT)

Financial institution information

We request that you include a blank, voided check or bank-generated account verification form for account and routing number verification.

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Account holder's name *

Routing number *

Account number *

Include leading zeros

Type of account * ◯ Checking ◯ Savings

Financial institution name*

Are you attaching a blank, void check or a bank-generated account verification form? ◯ Yes ◯ No

If neither of these documents are provided as requested, Alliance Health does not accept responsibility for the accuracy of the above typed/written account information submitted.

Remittance information

Complete only if the information differs from that in sections 2 and 3.

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Email
For electronic remittance forms to be sent

Phone

Address line 1
Street, P.O. Box, etc.

Address line 2
Suite, Building, etc.

City

State

Postal code

Authorization

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This authorization is effective as of the signature date below and is to remain in full force and effect until Alliance Health has received written notification of its termination in such time and such manner as to afford Alliance Health and the financial institution a reasonable opportunity to act on it, or until Alliance Health deems it necessary to terminate this agreement. Under penalties of perjury, I hereby certify the checking OR savings account indicated on this form are under my direct control and access; therefore, I authorize Alliance Health to initiate, change, or cancel credit entries to the financial institution account as indicated above. If my financial institution information changes, I agree to submit to Alliance Health a revised Authorization Agreement for Electronic Funds Transfer form.

I understand that by signing this form, payments issued will be Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Print name *

Signature (sign or type) *

Date (mm/dd/yyyy) *

x

III. IRS Form W-9

Attach a completed IRS W-9 unless you have been specifically instructed that Alliance Health already has a valid copy on file and an additional submission is not required.

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All vendors are required to provide a current IRS W-9. Please attach a completed and executed copy for your organization. If you do not already have a current W-9 on file, you may download one from the IRS at https://www.irs.gov/pub/irs-pdf/fw9.pdf.

Submission instructions

ONLINE: If you submitted this information online, no additional steps are required.

PAPER: If you did not submit the online form, please save and/or scan the completed packet (remember to include attachments) and email it to VendorSetup@AllianceHealthPlan.org.

If you selected a vendor type of 'Housing/TCLI', please also cc Housing@AllianceHealthPlan.org and bstaley@AllianceHealthPlan.org with your submission.