



Avalon Health Care Management Inc. Vendor Information Form

Request Type

☐

New

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Update

Date: _____

Company Information	Avalon location(s) using service:			
	Type of business:		Tax ID:	
	Name:		DBA:	
	Street:	City:	State:	Zip:
	Web Address:			

Contact Information	Main Representative		Billing		
	Name:		Name:	Title:	
	Title:		Email:		
	Email:		Phone Number:		
	Phone Number:		Remit Address:		
	Avalon Rep Who Initiated Services:		City:	State:	Zip:

Contract Included?	Yes	No	Online Billing Available?	Yes	No
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Contract Signer Name:	Contract Signer Email:
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Payment Details	Bank Name:	
	Routing Number:	Account Number:
	Remit Email:	
	Avalon standard payment terms are net 30 days. Contract negotiations or payment method may affect timing of when payment is submitted/received. To receive your payments in the most efficient manner, complete the payment detail fields above.	

Submission of this form must include a copy of your company's W9. In addition to contract negotiations and certificate of liability insurance, if applicable. Any changes to the information above require a new vendor information form be sent to apmailbox@avalonhealthcare.com.

PRINTED NAME: _____

SIGNATURE: _____