



Avalon Health Care Management Inc.

Vendor Information Form

Request Type

New 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

Contract Signer Name:

Contract Signer Email:

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: _____