Children’s Health System
Supplier Payment & Tax Information Form

To whom it may concern:

To insure payments to your account are properly processed and at the same time correctly reported for tax purposes, we request you complete Section A, along with the appropriate lines in Section B. Initial purchase will not be made until this form is properly completed and returned. Return the signed form to us. In addition, you should be aware that failure to give us your correct name/TIN combination may subject you to a penalty by the IRS. Detailed instructions are on the back of this form.

SECTION A: ACCOUNTS PAYABLE INFORMATION

CHS VENDOR #:____________

New Supplier_______ Change to Existing Supplier__________ Customer number_______

Buyer: ________________________________________

Type or print the Business Name to appear on payments together with the remit to address for those payments.

Complete Company Name:______________________________________________

Remit Address/PO BOX:______________________________________________

City________________ County__________________________State_________Zip Code________

Customer Service Phone Number: (____) ____-______ Customer Service Fax Number: (____) ____-______

Accounts Receivable Phone Number: (_____) _______-________ AR Fax Number:(____) ____-_________

Payment terms:

No discount offered: Net Due ___________ Days OR Net Due On ____________ Day of the Month

Discount Offered: Discount % ________ If Paid Within ________ Days, Net Due __________ Days

Discount %_________ If Paid on ____Day of Month, Net due __________ Days

Parent Company: ________________________ Other Affiliated Companies: ______________________

(If Applicable) (If Applicable)

SECTION B: TAX INFORMATION

Taxpayer Identification Numbers (TIN)

A. Business Type B. Name C. Social Security Number D. Employer Identification Number

1. Individual ________________ - - N/A

2. a. Sole Proprietorship ____________________ N/A -

b. Individual ____________________ - - N/A

3. a. Partnership ____________________ N/A -

b. First Partner Listed on TIN Application ____________________ N/A -

4. Corporation Providing Med. Or Health Care Services ____________________ N/A -

5. Corporation Providing Legal Services ____________________ N/A -

6. Other ____________________ N/A -

CERTIFICATION – Under penalties of perjury, I certify that the information provided on this form is correct.

Signature: _______________________________ Date signed: _______________________________

Print Name: _______________________________ Title: _______________________________
Children’s Health Systems
Supplier Tax Information Form

Instructions

Tax Information

Insert in the appropriate line of the information needed to report payment to you for tax purposes. The “name” to be entered in column B should be equal to the name listed on your application to the Internal Revenue Service for the TIN you entered in column C or D.

1. Businesses operation in the name of an individual should complete line 1., columns B and C. If you are a Sole Proprietorship operation in the name of an individual complete line 1 not 2.

2. Sole Proprietorships that applied for their TIN using the business name should complete 2a., columns B and D and line 2b, columns B and C. If the Sole Proprietor has not taken out an Employer Identification Number for its business name, insert NA in column D, line 2a.

3. Partnerships that applied for their TIN using the business name should complete line 3a. columns B and D.

   Partnerships that applied for their TIN using the names of the partners hold complete line 3b. columns B and D.

4. Corporations providing medical or health care services should complete line 4, columns B and D.

5. Corporations providing legal services should complete line 5, columns B and D.

6. Complete line 6 columns B and D for the payees listed below:

   a. Corporations providing services other than medical, health care or legal services.
   b. Organizations exempt from tax under sections 501© and 501(d) of the Internal Revenue Code.
   c. The government or any of its agencies of the United States; a state or foreign country.

7. After completing the appropriate lines please sign the certificate and return the original in the enclosed self-addressed stamped envelope.

Thank you for your prompt attention to this matter!