| Covenant Health System Vendor payment information | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Vendor Remit Information | | | | | | | | |
| Legal name as shown on your income tax return: | |  | | | | | | |
| Name on invoices: | |  | | | | SSN / EIN : |  | |
| Remit address: | |  | | | | | | |
| City: | |  | | State: |  | ZIP Code: |  | |
| Attach a list of any additional remit addresses | | | | | | | | |
| Vendor contact phone and email for any additional questions: | | | | | | | | |
| Contact at Covenant Health or subsidiary: | | | | | | | | |
| Please select if you will be providing goods or services to Covenant Health and specify/select the type.  Goods  Services (select type below)  Medical  Legal  Rent Payments  Interest Payments Royalty Payments  Non-Employee/Other Services  Please provide a brief description of the goods and/or services your company provides.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Submit a signed W-9 to:** [**vendormastermailbox@covhlth.com**](mailto:vendormastermailbox@covhlth.com) **with this form.** | | | | | | | | |
| Payment terms – To be completed by Accounts receivable | | | | | | | | |
| Accounts Receivable (AR) Contact: | | |  | | | Phone Number: | |  |
| AR Secondary Contact: | | |  | | | Phone Number: | |  |
| GHX ePay – Net 7 | | | PO and 810 invoice processing required | | | | | |
| Purchasing Card – Net 15 | | | AR email(s) for Credit Card remittance advice:  Vendor agrees to process Credit Card payment timely after receiving remittance email. | | | | | |
| Paper Check – Net 30 | | | | | | | | |
| Terms as outlined per signed contract on file with Covenant Corporate Materials Management. **Terms will default to Paper Check-Net 30 if no**  **Contract has been filed with Covenant Corporate Materials Management.** Terms: | | | | | | | | |
| Discount offered (be sure to include terms on each invoice) Terms: | | | | | | | | |
| Covenant Health accounts payable information | | | | | | | | |
| Invoice delivery  810 electronic  email pdf to [AccountsPayable@covhlth.com](mailto:AccountsPayable@covhlth.com)  mail invoice to PO Box 22790, Knoxville, TN 37933 | | | | | | | | |
| Covenant Health accounts Purchasing information | | | | | | | | |
| POs are required | | | | | | | | |
| Physical Location | |  | | | | | | |
| City: | |  | | State: |  | ZIP Code: |  | |
| PO delivery : | | | | | | | | |
| Accounts Receivable Authorized representative | | | | | | | | |
| This form should be completed by a vendor representative familiar with the company’s Accounts Receivable process. Covenant will not be responsible for delayed payments due to incorrect information provided on this form. Changes to this information could take three to six weeks to implement. | | | | | | | | |
| Completed By: |  | | | | | | | |
| Title: |  | | | | | Date: |  | |

FAX to: 865-374-6880 EMAIL to: [vendormastermailbox@covhlth.com](mailto:vendormastermailbox@covhlth.com) with the name on your invoices in the subject line.

**Be sure to include a signed copy of your W-9**