| Covenant Health System Vendor Application |
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| Vendor Remit Information |
| Legal name as shown on your income tax return: |       |
| Name on invoices: |       | SSN / EIN : |       |
| Remit address: |       |
| City: |       | State: |    | ZIP Code: |       |
| Vendor contact phone and email for any additional questions:       |
| Contact at Covenant Health or subsidiary:       |
| Compliance statements AND QUESTIONS |
| Covenant Health’s policy regarding the Deficit Reduction Act (DRA) and our Vendor Terms and Conditions (Vendor Agreement) are available through the Vendor page on our web site at: <http://www.covenanthealth.com/vendor-resources/>. Vendor is required to abide by the Covenant Health Terms and Conditions as to the work performed for Covenant Health or for any Covenant Health affiliate/subsidiary.  |
| (1) Are you an MD, DO, DDS, DMD, DPM, OD, or chiropractor? [ ] Yes [ ] No(2) Are you an “immediate family member” of any of the above? [ ] Yes [ ] No(3) Are you a business owned in whole or in part by an MD, DO, DDS, DMD, DPM, OD, or chiropractor, or by an “immediate family member” of the same? [ ] Yes [ ] No“Immediate family member” means a spouse, birth/adoptive parent, child, sibling, stepparent, stepchild, stepsibling, parent-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or the spouse of any of the foregoing.**If you have answered “Yes” to any of the above questions do not provide supplies or services without a written agreement that has received proper Covenant Health approvals**.Please provide the name and business location of the MD, DO, DDS, DMD, DPM, OD, or chiropractor(s):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(4) Brief description of the goods and/or services vendor will provide:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(5) Will vendor have access to patient information? [ ]  Yes \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No *(describe)* |
| conflict of interest |
| I certify there are no known Conflicts Of Interest as outlined in the Vendor Agreement. [ ]  No known conflicts [ ]  List attached |
| \*\*all FIVE Compliance questions must be COMPLETED for application to be processed\*\* |
| **The person signing below must be authorized to sign on behalf of the Vendor whose SS# or EIN is listed on this Application**. By signing below, Vendor represents and warrants that the information provided in this Application is accurate and complete; agrees to provide prompt written notice of any material change to such information via the fax number/e-mail address listed below; and agrees to abide by the Vendor Terms and Conditions, available at <http://www.covenanthealth.com/vendor-resources/> and incorporated herein by reference, as to the work performed for Covenant Health or for any Covenant Health affiliate/subsidiary.  |
| Vendor Authorized Signature: |       |
| Printed Name: |       |
| Title: |       | Date: |       |

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