| 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](mailto:vendormastermailbox@covhlth.com) with the name on your invoices in the subject line