**VENDOR DATA SHEET**

1. **Company Name:**

**Telephone:****Toll Free #** **Fax #**

**Address:**

**City:** **State:** **Zip + Four:**

**Email:****Agency Website:**

**Federal ID# or SSN:****Medicare #****Medicaid#**

**For Profit:** **or Non-Profit**  **Tax Exempt: Yes**  **No**  **Agency NPI #**

**Check Appropriate Box: Individual / Sole Proprietor**  **Corporation**  **Partnership**

**Limited Liability Company**

1. **Contract Administrator (Name that will appear on the contract)**

**Name:**        **Title:**

**Address:**

**Email:** **Telephone:**

**City:       State:       Zip + Four:**

1. **Contact Person For Billing Questions**

**Name:       Title:**

**Address:**

**Email:       Telephone:**

**City:       State:       Zip + Four:**

1. **Company Name and Address to Send Payments To**

**Agency Name:****Telephone:**

**Address:** **Email:**

**City:       State:       Zip + Four:**

1. **Contact Person For Program Related Matters**

**Name:       Title:**

**Address:**

**Email:       Telephone:**

**City:       State:       Zip + Four:**