Vendor Information Form

MEMBER INFORMATION	
Full Name (First, Middle, Last):	Medicaid or Palco ID:

VENDOR INFORMATION			
Name	FEIN or SSN of Payee		
Mailing Address	City	State	Zip Code
Contact Person	Phone Number	Email	
Pay Type: ☐ Paper Check	☐ EFT (If this option is selected, attach a direct deposit authorization agreement)		
☐ A W-9 is required for all vendors; the form is attached.			
Is this Vendor a Multi-Branch Provider? (Personal Care Services/Respite Providers ONLY; Services Codes: 99509/99509E & T1005SD) ☐ YES (If Yes, please complete the SDCB PCS/Respite Multi-Branch Vendor Locations form) ☐ NO			

Please describe the services that your agency will be providing and billing for:

***Please return this form via email to: docprocessing@conduent.com* or via fax to 1.866.302.6787.**

SDCB PCS/Respite Multi-Branch Vendor Locations

Please provide the full Physical Address and 9-digit Tax ID or FEIN of each office location below associated to this Vendor. **NOTE**: If Vendor was previously enrolled as Medicaid provider, each location associated with the SDCB PCS/Respite Vendor MUST be registered as a Medicaid provider and list the 9-digit Business Tax ID or FEIN below.

Physical Address:	FEIN/TAX ID:
City:	
State:	Zip Code:

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City:	
State:	Zip Code:

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City:	
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