New Supplier Form

Please fill out completely. Indicate "NA" if a field does not apply. A W-8 or W-9 MUST accompany this form. The section on physician ownership and minority supplier must be completed.

Corewell Health Contact Name: _____

Email Address: _____

Date: _____

Supplier's Full Legal Name: _____

Supplier's Payable to Name: _____

Who we make out the check to

Tax ID #: _____ *Include a current copy of your W-8 or W-9*

Invoice Payable to Address: _____

_____

Company Address: _____

_____

Indictate "same" is same as "Payable to" address

Customer Service Contact: _____

Customer Service Phone: _____

Customer Service Fax Number: _____

Customer Service Email: _____

Accounts Receivable Contact: _____

Accounts Receivable Phone: _____

Accounts Receivable Fax Number: _____

Accounts Receivable Email: _____

Payment Terms: _____ *Corewell Health's standard terms are NET45. We are open to terms that offer discounts.*

Are you a physician or owned by a physician or a physician's immediate family member? Please explain. N/A

Are you a Diverse Supplier defined as at least 51% ownership in one of the classes below? Put "Y" in approriate box(s).

Veteran Owned		*Veteran Owned Small Business*	
Service Disabled Veteran Owned		Service Disabled Veteran Small	
Minority Business Enterprise		*Disadvantage Business Enterprise*	
Economically Disadvantage		*Women Owned Enterprise*	
Women Owned Small Business		*Disadvantage Business Enterprise*	
Disability Owned Business		*LGBT Business Enterprise*	

Will you participate in an AP Card Program where invoices are paid through a VISA card? _____

If yes, you will be contacted at a future date by Spectrum Health Accounts Payable.