



SUPPLIER PROFILE FORM

1099 Legal Name:			
Business Name, if different from above:			
Physical Address:			
Remittance Address:			
Federal Tax ID:			
Payment Terms: Due Now			
DUNS Number:			
Primary Account Contact Name:			
Phone:		Fax:	
E-mail:		Website:	
Commodity Line/Services:			

Business Type:

- | | |
|---|--|
| <input type="checkbox"/> Individual/Sole Proprietor | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> C Corporation | <input type="checkbox"/> Limited Liability Corporation (Select LLC Type) |
| <input type="checkbox"/> S Corporation | <input type="checkbox"/> Other: |

Form 1099-MISC:

- | | |
|--|---|
| <input type="checkbox"/> Box 1, Rents | <input type="checkbox"/> Box 7, Nonemployee Compensation |
| <input type="checkbox"/> Box 3, Other Income | <input type="checkbox"/> Box 14, Gross Proceeds Paid to an Attorney |
| <input type="checkbox"/> Box 6, Medical/Health Care Payments | <input type="checkbox"/> Tax Exempt |

BANK INFORMATION

Bank Account Owner:	
E-mail (*Required for ACH delivery notification):	
Bank Name:	
Account Type:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account #:	Routing # (Must be 9 digits):

By submission of this form to Molina Healthcare, Inc., I authorize payment of invoice via ACH to the business account provided.

Name: _____ Title: _____

Signature: _____ Date: _____

