



## SUPPLIER PROFILE FORM

1099 Legal Name:			
Business Name, if different from above:			
Physical Address:			
Remittance Address:			
Federal Tax ID:			
Payment Terms:			
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: <a href="#">Click here to enter text.</a> |

**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 <span style="margin-left: 200px;"><input type="checkbox"/> Savings</span>
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: \_\_\_\_\_