Supplier Profile

Supplier No.: Company Name:

Physical Address:

Remittance Address:

Federal Tax ID:

Primary Account Contact Name:

Phone: Fax:

Email: Website:

Commodity Line / Services:

Parent Company:

Business type: ☐ Individual/Sole Proprietor ☐ C Corporation ☐ S Corporation

☐ Partnership ☐ LLC – ..... ☐ Other

Preferred Payment Method: Check ☐ ACH ☐

ACH Information

Name on Bank Account:

Bank Name: Acct Type: Checking ◯ Savings ◯

Account Number: Routing Transit No. (9 digits):

Email (for ACH notification delivery):

By filling the ACH Information and submitting this form to Molina Healthcare Inc., I, named as below, authorize payment of invoice(s) via ACH to the business account provided above.

Name: Title:

Signature: Date: