**VENDOR ADD/CHANGE/UPDATE FORM**



The Vendor ADD/CHANGE/UPDATE Form is used to Add/Change/Delete/Inactivate a vendor record within our Enterprise Resource Planning (ERP) system. **All** fields must be completed, indicating N/A if **Not** applicable.

***Note: New vendors/Vendor Name Changes must attach a completed W-9.***

ADD  CHANGE  DELETE  IN-ACTIVATE

**VENDOR INFORMATION – Vendor ID# (Completed by DWIHN) \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Tax ID# (EIN/SSN)**: Click or tap here to enter text. | | |
| **Vendor (Legal) Name:** Click or tap here to enter text. | | |
| **DBA (Payment) Name:** Click or tap here to enter text. | | |
| **Contact Name/Title:** Click or tap here to enter text. | | |
| **Email:** Click or tap here to enter text. | | **Phone #/Ext.#:** Click or tap here to enter text. |
| **Alternate Contact Name/Title:** Click or tap here to enter text. | | |
| **Email:** Click or tap here to enter text. | | **Phone #/Ext.#:** Click or tap here to enter text. |
| **Mailing Address:** Click or tap here to enter text. | | |
| **City:** Click or tap here to enter text. | **State:** Click or tap here to enter text. | **Zip Code:** Click or tap here to enter text. |
| **Remittance Address (if different from above):** Click or tap here to enter text. | | |
| **City:** Click or tap here to enter text. | **State:** Click or tap here to enter text. | **Zip Code:** Click or tap here to enter text. |
| **Reason for Change/Deletion/Inactivation:** Click or tap here to enter text. | | |

**BANKING INFORMATION (Note: Bank Confirmation Letter or Voided Check MUST be attached)**

|  |  |
| --- | --- |
| **Bank Institution Name**: Click or tap here to enter text. | |
| **Bank Routing #**: Click or tap here to enter text. | **Bank Account #**: Click or tap here to enter text. |

I certify that the information provided on this form is accurate. I hereby authorize Detroit Wayne Integrated Health Network (DWIHN) to initiate (ACH) Automated Clearing House credits to the above listed account for payments owed by DWIHN.

I, an authorized signer on the account above, hereby authorize Detroit Wayne Mental Health Authority, to originate Automated Clearinghouse (ACH) credits to this account for invoice payments for debts owed by DWMHA.

Authorized Signature: Date:

|  |
| --- |
| Printed Name/Title: Click or tap here to enter text. |

Submit the completed form and associated documents to DWIHN via email: Tyreesse Omani at [tomani@dwihn.org](mailto:tomani@dwihn.org) and Nicole Smith at [nsmith@dwihn.org](mailto:nsmith@dwihn.org) .

For questions, please email or call Accounts Payable at [tomani@dwmha.com,](mailto:tomani@dwmha.com) 313-344-9099 ext. 3267.