



HPC NEW CUSTOMER FORM

CUSTOMER/BUYER INFORMATION

Buyer's Name: _____ Phone: _____

Buyer's Email: _____

Facility/Company Name: _____

Parent Company (Health System) Name: _____

Facility (Shipping) Address: _____

City/State/Zip: _____

ACCOUNTING/BILLING INFORMATION

A/P Contact Name: _____

A/P Contact Email Address: _____

A/P Contact Phone: _____ Fax: _____

Email address for Invoices to be sent: _____

Corporate Credit Card: _____ Exp. Date: _____

Billing Address: _____

City/State/Zip: _____

Do you have a corporate FedEx/UPS shipping account we should charge freight to? Yes No

If yes, please provide your shipping account # and details: _____

Is your organization a member of a GPO (group purchasing organization)? Yes No

If yes, please enter your **GPO Member ID:** _____ and **select your GPO below:**

- | | |
|-------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> AdvantageTrust | <input type="checkbox"/> Premier |
| <input type="checkbox"/> CoreTrust | <input type="checkbox"/> Premier Continuum of Care (Non-Acute) |
| <input type="checkbox"/> HealthTrust (HPG/HCA) | <input type="checkbox"/> Premier Continuum of Care (REACH) |
| <input type="checkbox"/> Intalere | <input type="checkbox"/> PSMAConnect |
| <input type="checkbox"/> MedAssets | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Novation/UHC/VHA ("VIZIENT") | |

How were you referred to HPC? _____

*** We also require the following be submitted:**

- ✓ Copy of your company's W-9
- ✓ Sales Tax Exemption form, if applicable