Department of Revenue

Annual Provider Information Form
Fiscal Year _____

Name of Agency or Subdivision	Person to Contact		
Address	Telephone Number		
Name: Provider – Individual (Last Name First), Partnership or Legal Corporate Name Address: Street, City or Town and Zip Code	Provider's Social Security or FID Number (9-digit number)	Provider's Account Number	Total Amount Paid Provider in Previous Fiscal Year
Name			
Address			
Name			
Address			
Name			
Address			
Name			
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Name			
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Name			
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Name			
Address			
Name			
Address			

I declare under penalties of perjury that this form (including any accompanying schedules) and statements has been examiner by me and to the best of my knowledge and belief is true, correct and complete.

Signature _____ Date _____