



State of North Carolina Office of the State Controller

LINDA COMBS
STATE CONTROLLER

DATE

VENDOR NAME
VENDOR NAME
ADDRESS
CITY STATE ZIP CODE-POSTAL CODE

Dear Sir/Madam:

Enclosed is a copy of the Payment Verification Form. The North Carolina Office of the State Controller received this information from the state government agency that is paying you for goods or services that you provided. This form is to confirm that this information is correct. **Please correct any information on the form that is not correct and complete the remaining blanks on the form, if applicable. Then return the form to the address on the top of the form, email to OSC.Support.Services@osc.nc.gov or fax to (919) 981-5561 as soon as possible.** This will assure that any future payments will be correct. If you do not complete and return the form to us within 60 days, you will receive a duplicate form.

Completing and returning this form will **not** affect your Social Security payments, tax refunds, welfare checks, AFDC checks or any other entitlement checks.

If you have any questions about this form, please visit our web site at the following location:
http://www.osc.nc.gov/VPForm/Payment_Verification_Form_Information.html or call (919) 707-0795 and state that you have a question about the Payment Verification Form.

If you have questions about your payment, please contact the State agency with which you are doing business. The State Controller's Office controls the accuracy of these files but does not have information about your payment.

Businesses cannot substitute a W-9 for this form.

Your cooperation is greatly appreciated.

Thank you.

Attention Vendors! Vendors that regularly receive payments from State agencies may choose to have payments deposited electronically. Instructions and the form are located at: www.osc.nc.gov/vendorepayform. The Payment Verification Form on the back of this letter **must** be returned to verify information in our central files even if you do not choose to have payments deposited electronically.

Please contact the OSC Support Services Center at (919) 707-0795 with any questions.

MAILING ADDRESS: 1410 Mail Service Center, Raleigh, North Carolina 27699-1410
STREET ADDRESS: 3512 Bush Street, Raleigh, North Carolina 27609
Phone (919) 707-0500 ~ Fax (919) 981-5444
<http://www.osc.nc.gov> ~ An EEO/AA/AWD Employer

Office of the State Controller

Return to:

OSC Support Services Center

1410 Mail Service Center

Raleigh, NC 27699-1410

**Payment Verification Form**

Telephone: (919) 707-0795

FAX: (919) 981-5561

Email: OSC.Support.Services@osc.nc.gov

Section 6109 of the Internal Revenue Code requires you to furnish your correct TIN to persons who must file information returns with the IRS to report interest and certain other income paid to you. The IRS uses the numbers for identification purposes and to help verify the accuracy of your return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

Federal Tax ID Number/Social Security Number for Individuals (9 digits): (1)**Name of Vendor or Individual:** (2)**If Sole Proprietorship, owner's name:** (3)**Address for Ordering Goods and/or Services:**(4) Address(4) Address(4) City, State(4) Zip CodeCounty Name: (5)Fax Number: (6)Toll Free Phone Number: (6)Area Code/Phone Number: (6)E-Mail Address: (6)Contact Name: (6)**Remittance Address (if different from above):**(7) Address(7) Address(7) City, State(7) Zip CodeCounty Name: (8)Fax Number: (9)Toll Free Phone Number: (9)Area Code/Phone Number: (9)Email Address: (9)Contact Name: (9)**Type of Business Structure (Check ALL that apply.)** (10) Individual Sole Proprietorship Government: Federal or State or Local School/College/University: Public or Private Partnership Corporation: (check ALL that apply) Not-for-Profit Corporation Sub-Chapter S Corporation Medical/Health Corporation**Does your business provide:** (11) Goods Only Services Only Both Goods and Services**Does your business provide medical services?** (12) Yes No**Form Completed By:** (13)**Signature:** _____ **Title:** _____ **Date:** _____