**TO: Product Auditors and CVS Front Store Product Vendors**

**FROM: Dianne Sica, Director of Reverse & Redistribution**

**RE: Product Manufacturer Audit Request Form**

**DATE: May 13, 2019**

As of January 1st, 2019, CVS will charge a fee anytime a product manufacturer audit is performed at any of our Distribution Centers (DCs) and stores (when applicable). After the audit is complete, CVS will invoice the company that performed the audit based on the number of hours and labor cost for the DC. Invoices should be paid to CVS through ACH within 30 days of the invoice date. If a store visit is also requested, your organization may be charged if it requires access to the backroom or anywhere beyond the front store.

**Invoice Payment Instructions:**

1. Use the CVS ACH and Wire Transfer Instructions for The Bank of New York Mellon to transfer payment.
   * If you need a copy of this form, email [Duriel.Johnson@CVSHealth.com](mailto:Duriel.Johnson@CVSHealth.com).
2. Confirm the date of the transfer and the amount by emailing [Cash.Management3@CVSCaremark.com](mailto:Cash.Management3@CVSCaremark.com) and also cc, [Duriel.Johnson@CVSHealth.com](mailto:Duriel.Johnson@CVSHealth.com), [Dianne.Sica@CVSHealth.com](mailto:Dianne.Sica@CVSHealth.com); and [Sharon.Badeau@CVSHealth.com](mailto:Sharon.Badeau@CVSHealth.com).

Dianne Sica

Reverse & Redistribution

CVS Health

**Product Manufacturer DC Audit Request   
(Form must be submitted at least 45 days prior to the requested audit date range)**

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| **Audit Company Name:** | Select Audit Company Name |
| **Audit Requestor’s Name:** |  |
| **Audit Requestor’s Email Address:** |  |
| **CVS Product Vendor Name(s):** |  |
| **CVS Product Vendor Number(s):** |  |
| **CVS Product SKU Number(s):** |  |
| **CVS Category Manager(s) Email Addresses:** |  |
| **Requested CVS Distribution Centers:** | Choose the DC.Choose the DC.Choose the DC. |
| **Requested Audit Date Range:** |  |
| **Form Submission Date:** | Click here to enter a date. |

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| **Explain the Type and Goal of DC Audit** |
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| ***FOR INTERNAL USE ONLY BELOW*** | | |
| **Department** | **Approved** | **Approver Name** |
| **Reverse & Redistribution** |  |  |
| **Merchandising** |  |  |
| **Logistics Operations** |  |  |

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| **Date Approved** | Click here to enter a date. |

**Store Questionnaire**

**(*Complete only if one or more store visits are requested*)**

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| **Requested CVS Store Number(s) and Address (Click here for** [**CVS Store List**](https://cvssuppliers.com/sites/default/files/CVS%20Store%20Listing_03-22-2019.xlsx)**):** |  |
| **Store access requested:**  **(NOTE: Vendors will be invoiced for backroom access)** | **Front Store**  **Backroom** |
| **Requested Audit Date Range:** |  |

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| **Explain the Type and Goal of Store Audit** |
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| ***FOR INTERNAL USE ONLY BELOW*** | | |
| **Department** | **Approved** | **Approver Name** |
| **Store Operations** |  |  |

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| **Date Approved** | Click here to enter a date. |