

# INDIANA M.G.M.A. - STUDENT MEMBERSHIP APPLICATION

Membership Year January 1 to December 31

DUE DATE - March 1 (to be included in Membership Directory)

SPONSORED BY: \_\_\_\_\_

## MEMBER INFORMATION - PLEASE PRINT OR TYPE

First Name \_\_\_\_\_ M. I. \_\_\_\_\_ Last Name \_\_\_\_\_

Certification/Licensure \_\_\_\_\_ Job Title \_\_\_\_\_

Practice \_\_\_\_\_

Division/Department \_\_\_\_\_

Business Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Bus. Fax \_\_\_\_\_

E-mail 1 \_\_\_\_\_ E-mail 2 \_\_\_\_\_

➤ Do you wish to receive e-mail or fax broadcasts?  Email  Fax  No e-mail or fax broadcasts

➤ Do you wish to receive information regarding third party products and/or services that we believe are of interest to our members?  Yes  No

➤ Are you a member of National MGMA?  No  Yes - Membership # \_\_\_\_\_

➤ What is your ACMPE Certification?  None  Nominee  CMPE  FACMPE

➤ PAYMENT:  Student - \$25.00

Check - Make check payable to "Indiana MGMA"  Credit Card - Complete & sign credit authorization below

Please charge \$ \_\_\_\_\_ to my  VISA  MASTER CARD

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder Name [Print] \_\_\_\_\_

Authorized Signature \_\_\_\_\_

➤ Mail completed application with payment to: Indiana MGMA, 539 Dylan Drive Avon, IN 46123

➤ -OR- Fax to: 317-872-0795

Signature \_\_\_\_\_

Date \_\_\_\_\_

PLEASE COMPLETE INFORMATION ON REVERSE SIDE



Indiana  
A State Affiliate

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➤ Indicate the primary purpose of your organization: [Check only one]

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Architecture/Construct/Design | <input type="checkbox"/> IT/Software Products & Service | <input type="checkbox"/> Medical Service Organization |
| <input type="checkbox"/> Billing/Reimbursement         | <input type="checkbox"/> Insurance Carrier              | <input type="checkbox"/> Office Systems/Supply        |
| <input type="checkbox"/> Business/Management Service   | <input type="checkbox"/> Insurance Products & Service   | <input type="checkbox"/> Pharmaceutical               |
| <input type="checkbox"/> Financial/Tax Service         | <input type="checkbox"/> Legal Service                  | <input type="checkbox"/> Professional Association     |
| <input type="checkbox"/> Government/Legislative        | <input type="checkbox"/> Medical/Clinical Care          | <input type="checkbox"/> Staffing                     |
| <input type="checkbox"/> Health Care Consulting        | <input type="checkbox"/> Medical Equipment & Sales      | <input type="checkbox"/> Training                     |
|  |   | <input type="checkbox"/> Other _____                  |

➤ Indicate your job function: [Check only one]

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Academic Organization position | <input type="checkbox"/> CEO level position     | <input type="checkbox"/> Partner                    |
| <input type="checkbox"/> Assistant/Associate level      | <input type="checkbox"/> Consultant             | <input type="checkbox"/> Physician                  |
| <input type="checkbox"/> Billing/Coding/Reimbursement   | <input type="checkbox"/> Financial Professional | <input type="checkbox"/> Practice Administrator     |
|   | <input type="checkbox"/> Manager level position | <input type="checkbox"/> VP/Director level position |
|   | <input type="checkbox"/> Office Support         |   |

➤ Medical Practices, only: [Check one in each category]

- | <u>Setting</u>                                     | <u>Structure</u>                           | <u>Practice Specialty</u>   |
|--|--|---|
| <input type="checkbox"/> Academic/University       | <input type="checkbox"/> Solo Practitioner | <input type="checkbox"/> Multi-Specialty - primary/specialty care |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Group Practice    | <input type="checkbox"/> Multi-Specialty - specialty care only    |
| <input type="checkbox"/> Community Health Center   | Number of Physicians:<br>_____             | <input type="checkbox"/> Multi-Specialty - primary care only      |
| <input type="checkbox"/> Private Practice          |  | <input type="checkbox"/> Single Specialty                         |

➤ Clinical Specialty \_\_\_\_\_

➤ Practice Management System \_\_\_\_\_

➤ Do you have an EMR System? \_\_\_Yes \_\_\_No

➤ If yes, which system do you use? \_\_\_\_\_