



Membership Application

Contact Information

WERE YOU REFERRED? Yes ___ No ___ IF YES, BY WHOM? _____

NAME: _____

TITLE: _____ CREDENTIALS: _____

ORGANIZATION: _____

NATIONAL MEMBER? Yes ___ No ___ GENDER M ___ F ___ YEAR OF BIRTH _____

HIGHEST EDUCATION LEVEL COMPLETED _____

YEAR STARTED IN MEDICAL PRACTICE MANAGEMENT _____

WORK ADDRESS: _____

WORK CITY/STATE/ZIP _____

WORK PHONE: _____ WORK EXTENSION: _____ WORK FAX: _____

EMAIL: _____

HOME ADDRESS: _____

HOME CITY/STATE/ZIP _____

HOME PHONE: _____ CELL PHONE: _____

Demographic Information

Practice type:

- ___ Single Specialty
- ___ Multi-specialty (primary & specialty care)
- ___ Multi-specialty (primary care only)
- ___ Multi-specialty (specialty care only)

Specialty:

Practice Ownership:

- ___ Physician Owned
- ___ Hospital Owned
- ___ FQRHC/RHC
- ___ Other

Providers

Number of full-time/FTE physicians _____

Number of full-time non-physician providers _____

Circle the networks you participate in

Medicare Medicaid BCBS
 Aetna Cigna UHC Magnolia Plans

What Practice Management Software do you use? _____

Are you using an EMR? _____ If yes, which software? _____

Please check membership category:

Active \$100 _____ Allied \$150 _____ Student \$50 _____

Payment Information

Check Enclosed _____ Send Invoice _____ Charge my Credit Card _____

Credit Card Authorization:

Name on card: _____
 Billing Address: _____
 Billing State & Zip: _____
 Card Number: _____
 Type of Card: Visa MasterCard AmEx Discover Expiration Date: _____

Mail completed form & check to

MGMA of MS
 313 Telly Rd. #68
 Picayune, MS 39466

CVV Code: _____

For questions or more information: Kristina Smith (601)569-6659 or info@mgmams.com