MGMA®
ST. LOUIS, MO.

Business Partner Membership Application

Company

Primary Company Representative*

Title

Address

City State Zip Code

Phone Ext.

Fax

Email

Referred By

**Please list additional secondary company representatives and their contact information on the reverse side of this form.*

Please select up to three categories in which you/your company should be listed:

___ Billing and Collections
___ Clinical Services
___ Consultants
___ Document Management
___ EHR/Practice Management Systems
___ Financial Services (Banking & Accounting)
___ Human Resources/Staffing
___ Information Technology/Communication
___ Insurance (Malpractice/Employee Benefits)
___ Legal Services
___ Marketing
___ Medical Transcription
___ Office Services
___ Real Estate
___ Other *(Please Specify: _____)*

Brief Company Description (80 words max):
You may also e-mail your company description to ***administrator@mgmastl.org***

Please send your company logo (high-res, print-ready, .pdf, .jpg, or .png file-types accepted) to **administrator@mgmastl.org**.

Business Partner - $250

Individuals or organization that provide purchased services and/or products to the health care industry.

Payment Information:

Check Enclosed **or** Credit Card (Circle One)
MasterCard Visa Discover Amex

Name on Card

Card Number

Expiration Date Billing Zip Code

Amount to Charge

Signature

Complete this form and send with payment to:

Greater St. Louis MGMA
P.O. Box 16012
St. Louis, MO 63105
Phone: **(314) 499-9344**
E-mail: **administrator@mgmastl.org**