Membership Application

Name_____ **Title**_____

Name of Institution, Organization, Agency, Department, Office, Program, etc:

_____

Type of Institution, Organization, Agency, Department, Office, Program, etc:

_____

Mailing Address:

_____

_____

_____

Work Phone: _____ **Fax Number:** _____

E-mail Address: _

_____

Membership Category: Please indicate your level of membership
Hospital/Health System

X	Category	# of Staffed Beds	Dues Amount
	Level 1	≤ 25 beds	$200
	Level 2	26-49 beds	$300
	Level 3	50-200 beds	$400
	Level 4	201-+ beds	$600

Free standing Clinics/FHQCs/RHCs/Online Provider Groups:

X	Category	# of FTE Providers	Dues Amount
	Level 1	1-10 FTE providers	$200
	Level 2	11-25 FTE providers	$300
	Level 3	26-100 FTE providers	$400
	Level 4	101+ FTE providers	$500

Payors:

X	Category	# of Montana Enrollees	Dues Amount
	Large	(50,000+ enrollees)	$1000
	Medium	(10,000-49,999 enrollees)	$800
	Small	(<10,000 enrollees)	$600
	Medicare Advantage Plans	N/A	$800

Professional Associations/Groups/Educational Organizations:

☐ $150

Individuals:

☐ Regular - $150

☐ Student - $75

☐ Legacy Member- $0

Vendor Sponsors:

X	Category	Amount
	Copper	$250
	Silver	$500
	Gold	$1,000
	Platinum	$5,000

The fiscal and membership year of MTA is from July 1 - June 30. Make checks payable to MTA. Please send your MTA membership application and membership dues to:

Nichole Perisho MTA Treasurer, 2319 Alpine Ct, Whitefish, MT 59937. Phone: 406-751-3067; e-mail: nperisho@krmc.org