FMA FALL INSURANCE SUMMIT 2019

REGISTRATION FORM

November 8, 2019
at the Nicholson Center in Orlando

November 8, 2019 | Nicholson Center, Orlando

Make sure you're being paid fairly for the patient care you provide by registering for the 2019 FMA Insurance Summit. You or members of your office staff will be able to speak directly with representatives from major insurance carriers to discuss the issues that matter to you. You'll get access to invaluable information on how to:

- File a claim
- File a dispute or appeal
- Handle policy and process changes for providers
- Obtain an authorization

> "I appreciated the one-to-one interaction with insurance representatives."

94%

Of attendees would recommend it to others.

71%

Of attendees said they would make changes in their practices based on Summit presentations.

> "Very informational! The speakers were awesome."

96%

Of attendees said the Summit met or exceeded their expectations.

Agents representing UnitedHealthcare, Florida Blue, Cigna, Sunshine Health, The Agency for Health Care Administration, and First Coast Service Options are expected to attend.

*Please list which payers you would like to visit: _____

Pricing

		Quantity
FMA Member Physician or Member Physician Staff	$189	_____
Additional FMA Member Physician or Member Physician Staff	$139	_____
Non-Member Physician or Non-Member Physician Staff	$289	_____
Residents	$99	_____
SPECIAL — **5 FMA Member Physicians or Member Physician Staff**	$599	_____

(Enter attendee information on back. More than 5? Call for group rate.)

Payment **Amount Total** _____

☐ Check enclosed payable to the FMA ☐ Discover ☐ American Express ☐ MasterCard ☐ Visa

Authorized Signature _____

Type cardholder name as authorization.

Credit Card Number _____ Expiration _____ Security Code _____

Fax: Printed form to (850) 224-6627 **Mail:** The FMA, 1430 Piedmont Dr. East, Tallahassee, FL 32308 **Call:** (850) 224-6496

Registration Information

Physician Information: *(required for $189 Member pricing)* ☐ Physician attending summit ☐ Not attending

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

For additional member physicians or member staff *($139 each additional attendee)* or non-member physicians and/or staff *($289 each attendee).*

Contact Information: Attendee

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

Contact Information: Attendee

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

Contact Information: Attendee

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

Contact Information: Attendee

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

Contact Information: Attendee

Last Name ______________________ First Name ______________________

Address ______________________ City ______________________ State __________ Zip ________

Practice Name ______________________ Job Title ______________________

Phone (   ) ______________________ Fax (   ) ______________________ Email ______________________

Save   Print