

FMA INSURANCE SUMMIT

2018

REGISTRATION FORM

Thursday, August 2, 2018
Loews Sapphire Falls Resort
at Universal Orlando

Thursday, August 2, 2018 | Orlando

Make sure you're being paid fairly for the patient care you provide by registering for the 2018 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.”

“Very informational! The speakers were awesome.”

94%

Of attendees would recommend it to others.

71%

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

96%

Of attendees said the Summit met or exceeded their expectations.

*Last year's agents included Aetna, Cigna, Florida Blue, WellCare, UnitedHealthcare, Agency for Health Care Administration and First Coast Service Options.**

*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 _____

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 _____

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