



AMERICAN
ASSOCIATION
OF PAYERS,
ADMINISTRATORS
AND NETWORKS

Membership Application:

To join AAPAN today, please complete the information below:

Primary Contact: _____

Title: _____

Company Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Email: _____ Web Site: _____

Organization Type: *(check all that apply)*

- Commercial Health
- Medicare
- Medicaid
- Workers' Compensation
- Auto Liability

Your organization is a: *(check all that apply)*

- Health Plan, Preferred Provider Organization or Network
- Payer
- Third Party Administrator (TPA)
- Specialty Network
- Pharmacy Benefit Manager (PBM)
- Stop Loss/MGU
- Care Management/Cost Containment
- Vendor
- Other _____

Please email this application to Pat Ciresi at pciresi@aapan.org or fax to 502.403.1129.
Someone from AAPAN will be in contact once the application is reviewed.