AAPAN

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 Amy Seiler at aseiler@aapan.org. Someone from AAPAN will be in contact once the application is reviewed.

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