



## Application of Payor Advisory/Practice Staff

Please print or type.

Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employed by: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Office Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Other Current Professional organization memberships: \_\_\_\_\_

List any practice(s), clinic(s), hospital(s), or surgical/treatment center with which you are affiliated:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please briefly describe the nature of your position: \_\_\_\_\_

\_\_\_\_\_

Are you currently a member of LOS's Payor Advisory Committee? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, would you like to participate in the monthly meetings via teleconference? Yes \_\_\_\_\_ No \_\_\_\_\_

Would you be interested in participating in a list serve or teleconferences on reimbursement issues?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Questions:

Call: 918-261-8951

Fax: 918-274-8354

Email: [MaryJo@mjexecmgmt.com](mailto:MaryJo@mjexecmgmt.com)

Mail: LOS

8805 N 145<sup>th</sup> E Ave, Ste 203

Owasso, OK 74055

**PLEASE FAX THIS FORM TO 918-274-8354**