New Mexico Coalition for Healthcare Value
Membership Application

Thank you for your interest in the New Mexico Coalition for Healthcare Value. Please complete this form regarding your organization's New Mexico operations. Having a better picture of the characteristics of coalition members gives the Board of Directors and Committees a clearer idea of what would be of most value to members. Once submitted, this application goes before the Board of Directors for approval. Once approved, your organization will be invoiced for dues.

Please complete the following and email to swilson@nmhealthcarevalue.org

Name of Organization: _____
Address: _____
City: _____ State: _____ Zip code: _____

Primary Contact: _____

Title: _____
Phone: _____ Cell: _____

E-mail:_____

Type of Organization: ☐ Healthcare Purchaser ☐ Healthcare Provider ☐ Health Plan
☐ Health Support Organization ☐ Affiliate

Organization Information (please state briefly the business function of your organization)
_____
_____
_____

Number of New Mexico employees: _____

For Employer Purchasers:

Do you self-insure? _____Yes _____No

If yes, approximately what percentage of your covered lives is through self-insurance: _____%

Do you purchase fully insured products from health plans? _____Yes _____No

If yes, please list the health plans you currently contract with:
_____

Approximate number of covered lives:

Employees _____ Dependents _____ Retirees _____ Total Covered Lives _____

For Healthcare Providers: Number of providers in New Mexico ____
For Hospitals: Number of Beds _____

** Note: Membership dues are invoiced annually and are for 12 months. Dues must be paid within one month of being invoiced. No refund of annual dues is available if your organization chooses to leave the Coalition before the 12-month membership period ends.*