BeMedWise Program at NeedyMeds  
2020 BeMedWise Supporter Application  
(January 1 – December 31)

Please complete and return this application along with payment to: NeedyMeds, 50 Whittemore Street, PO Box 219  
Gloucester, MA 01931. For your convenience, payment may be made by check (payable to BeMedWise) or credit card.  
Click here to view the BeMedWise Supporter Categories and Benefits.

Credit card payments will be accepted for Public Sector ($200) and Non-Profit HCP Organizations ($1,000) only and  
may be faxed to (206) 260-8850 (or emailed to deborah.davidson@needymeds.org /mailed to the address below).  
BeMedWise will send you an invoice for all categories $2,500 and above.

**My organization / company qualifies for the annual dues tier marked below: (Check One)**

1. _______ $15,000 CHAMPION  
2. _______ $10,000 ALLY- Business operational ≥ 3 years  
3. _______ $2,500 FRIEND - Healthcare provider & trade organizations; Business startups operational < 3 years  
4. _______ $1,000 NON-PROFIT - Healthcare Professional Organizations  
5. _______ $200 PUBLIC SECTOR - Consumer/patient advocacy groups, universities, national, local government  
   agencies (includes non-profits whose primary membership or constituency are patients and caregivers,  
   including disease or consumer advocacy organizations).

**Data for Membership Record (please complete each item)**

BeMedWise MEMBER CONTACT:

Name/Title: ________________________________________________________________

Organization/Company: __________________________________________ Website: ____________

Address: ________________________________________________________________

City: __________________ State: ___________ Zip code: __________________

Phone: ( ) __________ Fax: ( ) __________ E-mail: ____________________________

NeedyMeds Federal Tax ID: 46-3091990

Payment Method

Check payable to BeMedWise (U.S. Dollars)  
Electronic Direct Deposit Contact Deborah.Davidson@needymeds.org to obtain bank routing information.

Credit Card - Authorized Amount: $1,000 $200  
Visa Mastercard American Express Discover  
Diner's Club JCB

Card #: ___________________________ Expiration Date: _________/_______ Security Code: _____________

Authorized Signature: ___________________________________________ Date: _________________

Send payment to: BeMedWise, 50 Whittemore Street, PO Box 219 Gloucester, MA 01931  
TEL: 978-281-6666 FAX: 206-260-8850 Website: BeMedWise.org  
Questions contact: Deborah Davidson at deborah.davidson@needymeds.org