

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 \geq 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