



**Michigan Medical Billers Association (MMBA) &
American Medical Billing Association (AMBA)**
Certification Program
Certified Medical Reimbursement Specialist (CMRS)

Members Name: _____ Title: _____

Employer: _____

Address: _____

Suite #: _____ City: _____ Zip: _____ County: _____

Phone: () _____ email: _____

(please select one)

<input type="checkbox"/> CMRS Test, Study Guide and AMBA Membership	MMBA Member Price	\$450.00
<input type="checkbox"/> CMRS Test, Study Guide and AMBA Membership, MMBA membership	Non Member	\$600.00

SUBMIT PAYMENT: *(check one)*

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____ - _____ - _____

Expiration Date ____/____/____

CVV2 _____

(3 digit number on back of card / 4 digits on front of AMEX)

Billing Address _____

City, State, Zip _____

Phone (____) - ____ - ____

Signature _____

Date _____

☐ Check – Make Checks Payable to:
MMBA

Mail Application & Check to:

Michigan Medical Billers Association
P.O. Box 4031
East Lansing MI 48826

Toll Free: (885)360-3401

Fax: (248) 247-2722
info@mmbaonline.org

For Office use only:

Promo Code AMBA