NHCAA
National Health Care Anti-Fraud Association®

NHCAA INSTITUTE EST. 2000 ® ACCREDITED HEALTH CARE FRAUD INVESTIGATOR AHFI ®

A PRIVATE - PUBLIC PARTNERSHIP AGAINST HEALTH CARE FRAUD

Individual Member Application

I ORGANIZATION INFORMATION

Name ____

Title ____________________ Designation ____________________

Organization ____

Address ____

City ____________________ State ______ Zip __________

Phone ____________________ Fax ____________________

Email ____________________ Organization Website ____________________

How did you hear about us? ______________________________

II MEMBERSHIP CATEGORY

Individual Members shall be persons occupying managerial, supervisory or professional positions in organizations eligible for membership as a Member Organization, Affiliate Member, Supporting Member, or Law Enforcement Liaison.

EMPLOYER ORGANIZATION TYPE:

- ☐ Commercial Health Insurer
- ☐ Self-Insured Organization
- ☐ Professional Disciplinary/Regulatory Organization
- ☐ Medicare PSC with Full Benefit Integrity Contract
- ☐ Not-For-Profit Health Insurer
- ☐ Third Party Administrator
- ☐ Government Agency
- ☐ Insurance Company (non-health lines)
- ☐ Other ____________________

III DESCRIPTION OF YOUR ORGANIZATION'S ACTIVITIES

Please provide a description of your organization, including your organization's special investigative unit, and of the products and/or services it currently offers.

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INDIVIDUAL MEMBERSHIP DUES (12 MONTHS): $275

IV PAYMENT INFORMATION

☐ Check (Check Enclosed)

☐ Purchase Order #: ______________________________

Credit Card: ☐ AmEx ☐ Discover ☐ MC ☐ Visa

Credit Card Account # ______________________________ Exp ____________

Cardholder Name (Print) ______________________________ Security Code ________

Billing Address ______________________________

City ______________________________ State ________ Zip ____________

Signature ______________________________ Date ____________

I understand that by providing these mailing addresses, email addresses, and telephone and fax numbers, I give consent for myself and the other contacts provided to receive communications sent by or on behalf of the National Health Care Anti-Fraud Association (NHCAA) or The NHCAA Institute for Health Care Fraud Prevention (The NHCAA Institute) via regular mail, email, telephone or fax.

Print Name ______________________________

Signature ______________________________ **Date** ____________

V RETURN THIS COMPLETED FORM BY MAIL OR BY SECURE FAX:

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

1220 L Street NW, Suite 815
Washington, DC 20005

Phone: **202.349.7996**
Secure Fax: **202.785.6764***

Email: **nhcaa@nhcaa.org**
Web: **www.nhcaa.org**

** Applications can be faxed if paying by American Express, Discover, MasterCard, and Visa*