NHCAA
National Health Care Anti-Fraud Association
1220 L Street NW
Suite 600
Washington, DC 20005

Individual Membership Application

Name ____________________

Title ____________________ **Designation** ____________________

Organization ____________________

Address ____________________

City ____________________ State __________ Zip __________

Phone ____________________ Fax ____________________

Email ____________________ Organization Website ____________________

HOW DID YOU HEAR ABOUT US? ____________________

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

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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A PRIVATE-PUBLIC PARTNERSHIP AGAINST HEALTH CARE FRAUD

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INDIVIDUAL MEMBERSHIP DUES (12 MONTHS): $275

PAYMENT INFORMATION

☐ CHECK *(Enclosed)* CREDIT CARD: ☐ AmEx ☐ Discover ☐ MC ☐ Visa

CREDIT CARD ACCOUNT # ______________________ EXP ______________

CARDHOLDER NAME (PRINT) ______________________ SECURITY CODE ______________

BILLING ADDRESS ______________________

CITY ______________________ STATE ________ ZIP CODE ______________

SIGNATURE ______________________ DATE ______________

I understand that by providing my mailing address, email address, and telephone and fax numbers, I consent 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 ______________

RETURN THIS COMPLETED APPLICATION FORM AND PAYMENT TO:

By mail: National Health Care Anti-Fraud Association
1220 L Street, NW, Suite 600 • Washington, DC 20005

By email: nhcaa@nhcaa.org

By fax: 202.785.6764