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

Platinum, Premier, and Standard Supporting Member Application

Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____ Organization Website _____

Reset Section

PRIMARY MEMBERSHIP CONTACT

Name _____

Title _____ Designation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

EXHIBIT CONTACT

Name _____

Title _____ Designation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

BUSINESS DEVELOPMENT CONTACT

Name _____

Title _____ Designation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

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

Platinum, Premier, and Standard Supporting Member Application

FINANCE & ACCOUNTING CONTACT

Name _____

Title _____ Designation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

MEMBERSHIP CATEGORY

Membership in NHCAA as a Supporting Member is available to any corporation, partnership, association, or other institution or organization which (i) does not qualify as a Member Organization or an Affiliate Member, and (ii) undertakes to support the purposes of NHCAA as set forth in its Certificate of Incorporation and Bylaws, or has principles and purposes compatible with the principles and purposes of NHCAA, as determined by criteria established by the Board of Directors.

MEMBERSHIP LEVEL

- ☐ Platinum Supporting Member Annual Dues Rate: $25,000
- ☐ Premier Supporting Member Annual Dues Rate: $19,000
- ☐ Standard Supporting Member Annual Dues Rate: $7,000

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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 _____

Reset Section

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 _____

Reset Section

RETURN THIS COMPLETED APPLICATION FORM AND PAYMENT TO:

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