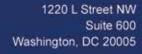




## Platinum, Premier, and Standard Supporting Member Application

Organization		
Address		
City	State	Zip
Phone	Fax	
Email	Organization Website	
PRIMARY MEMBERSHIP CONTACT		
Name		
Title		
Address		
City	State	Zip
Phone	Fax	
Email		
EXHIBIT CONTACT		
Name		
Title	Designation	
Address		
City	State	Zip
Phone	Fax	
Email		
BUSINESS DEVELOPMENT CONTACT		
Name		
Title	Designation	
Address		
City	State	Zip
Phone	Fax	

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## Platinum, Premier, and Standard Supporting Member Application

## FINANCE & ACCOUNTING CONTACT \_\_\_\_\_\_ Designation \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone\_\_\_\_\_\_ Fax \_\_\_\_\_ 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 PAYMENT INFORMATION ☐ CHECK (Enclosed) CREDIT CARD: ☐ AmEx Discover $\square$ MC ☐ Visa CREDIT CARD ACCOUNT # \_\_\_ \_\_\_\_\_ EXP \_\_\_\_\_ CARDHOLDER NAME (PRINT) \_\_\_\_\_\_ SECURITY CODE \_\_\_\_\_\_ BILLING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_\_ STATE \_\_\_\_ ZIP CODE \_\_\_\_\_ 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 \_\_\_ \_\_\_ Date \_\_ Signature \_\_\_\_

## RETURN THIS COMPLETED APPLICATION FORM AND PAYMENT TO:

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

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