NHCAA
National Health Care Anti-Fraud Association®

1220 L Street NW
Suite 815
Washington, DC 20005

Member Organization Application

Membership in NHCAA as a Member Organization is available to the following entities:

1) Companies that are engaged in the financing, administration or provision of health care insurance
2) Non-governmental organizations performing benefit integrity functions under contract with government sponsored health care insurance programs
3) Organizations that self-insure and self-administer health insurance benefits.

APPLICANT INFORMATION

Organization _____

Address _____

City _____ State _____ Zip _____

Main Phone _____ Main Fax _____

Website _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Reset Section

PRIMARY CONTACT (NHCAA Membership Forum Representative)

Name _____

Title _____

Department _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

ADDITIONAL CONTACT

Name _____

Title _____

Department _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Reset Section

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Name _____

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TAX STATUS

- ☐ For-Profit/Publicly Traded
- ☐ For-Profit/Privately Held
- ☐ Not-for-Profit

LINES OF BUSINESS (Check all that apply)

- ☐ Commercial Health Insurer
- ☐ Medicaid
- ☐ Tricare
- ☐ FEHBP
- ☐ Third Party Administrator
- ☐ Medicare Advantage
- ☐ Medicare Part D
- ☐ Self-Insured and Self-Administered Organization
- ☐ Medicare and/or Medicaid Integrity Contractor
- ☐ Other:_____

PRODUCTS OFFERED (Check all that apply))

☐ HMO ☐ Indemnity ☐ PPO ☐ Dental ☐ HSA

☐ Other:_____

ADDITIONAL PRODUCTS

Please indicate which, if any, of the following products your organization offers.

☐ Disability ☐ Workers Compensation ☐ Long Term Care

OWNERSHIP & BUSINESS ENTITIES

a) Is your company a subsidiary of another company?

☐ yes ☐ no

If yes, what is the name of the parent company?

_____

b) Please provide the names of business units, subsidiaries or affiliates, if any, that would claim membership as part of your organization's membership.*

_____

Reset Column

GEOGRAPHIC PRESENCE

Please provide a listing of the states in which your organization is licensed to do business (you may attach a list if the space below is insufficient)

_____

_____

DUES

Organizational Membership dues are based on the amount of total annual health benefits paid per year. Please provide the total annual health benefits paid out in the most recently completed year.

TOTAL ANNUAL HEALTH BENEFITS PAID	ANNUAL DUES
☐ $1 Billion or more	$30,320
☐ $500 Million to $999 Million	$24,255
☐ $100 Million to $499 Million	$18,200
☐ Less than $100 Million	$12,130
☐ Public Program Integrity Contractor	$16,550

Membership Dues To Be Paid

$ 0

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** If membership is intended to extend to business units, subsidiaries and affiliates, the total reported health benefits paid out should also include health benefits paid out by these entities.*

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 815 • Washington, DC 20005