NHCAA
National Health Care Anti-Fraud Association®

A PRIVATE - PUBLIC PARTNERSHIP AGAINST HEALTH CARE FRAUD

Individual Member Application

MEMBERSHIP IN NHCAA AS AN INDIVIDUAL MEMBER

Individual membership is available to people occupying managerial, supervisory, or professional positions in such reimbursement organizations. In addition, individuals who hold positions in local, state or federal law enforcement, prosecutorial or regulatory agencies; or in professional associations or professional disciplinary organizations are eligible for membership.

Individuals who are temporarily unemployed are able to put their membership on hold. Membership is renewed annually.

I INDIVIDUAL 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 FRAUD FIGHTING ACTIVITIES

Please provide a description of the work you do to fight health care fraud and the products and/or services your company currently offers.

_____

_____

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: **202.349.7984**
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*