NHCAA
National Health Care Anti-Fraud Association®

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Due upon receipt

AHFI INVOICE

Name:
Organization:
Address:
City:
State:
Zip Code:
Title:
Phone:
Fax:
E-mail:

I understand that by providing my mailing address, e-mail, telephone and fax number, 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, e-mail, telephone and fax.

Signature _____ Date _____

Quantity	Item Description	**Total Charge**
1	AHFI Accreditation Renewal	**$325.00**

Eligibility Verification

I certify that I am currently eligible for NHCAA Individual Membership as defined in the AHFI Guidelines. I have completed 48 hours of health care anti-fraud training, at least 24 of which were via NHCAA programs in the past 3 years.

Signature:_____ Date:_____

Please return this form with payment.

Method of Dues Payment

□ Check (Make checks payable to NHCAA) □ Credit Card □ American Express □ Discover □ MasterCard □ VISA

Credit Card Account # Expiration Date Security Code

Cardholder Name (Print)

Billing Address

City State Zip

Signature Date