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Due upon receipt

AHFI INVOICE

Name:
Organization:
Address:
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State:
Zip Code:
Title:
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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 _____

<u>Quantity</u>	<u>Item Description</u>	<u>Total Charge</u>
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 60 hours of health care anti-fraud training, 36 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 _____