NHCAA
National Health Care Anti-Fraud Association®

A PRIVATE - PUBLIC PARTNERSHIP AGAINST HEALTH CARE FRAUD

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.**

I ORGANIZATION INFORMATION

Organization _____

Corporate Address _____

City _____ State _____ Zip _____

Main Phone _____ Main Fax _____

Website _____

II PRIMARY CONTACT *(NHCAA Membership Forum Representative)*

Name _____

Title _____

Department _____

Address if different from Organization _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

III ORGANIZATION DETAILS

TAX STATUS

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

GEOGRAPHIC PRESENCE

In which states and territories is your organization licensed to provide health insurance? _____

WHICH LINES OF BUSINESS AND INSURANCE PRODUCTS DOES YOUR ORGANIZATION OFFER? *(Check all that apply)*

☐ Behavioral Health
☐ Commercial Group Health Insurer
☐ Dental
☐ Disability
☐ Federal Employees Health Benefits Program (FEHBP)
☐ Federal Health Insurance Marketplace (Exchange)
☐ Health Maintenance Org. (HMO)
☐ Health Savings Account
☐ Indemnity (FFS)
☐ Individual Private Health Insurance
☐ Long-Term Care
☐ Managed Medicare Plan
☐ Medicaid
☐ Medicaid Integrity Contractor
☐ Medicare Advantage (Part C)
☐ Medicare Integrity Contractor
☐ Medicare Part D (Rx)
☐ Medicare-Medicaid Plan (MMP)
☐ Medigap
☐ Pharmacy
☐ Preferred Provider Org. (PPO)
☐ SCHIP
☐ Self-Insured/Self-Administered Org.
☐ State Health Insurance Marketplace (Exchange)
☐ Third Party Administrator/ASO
☐ TRICARE
☐ Workers Compensation
☐ Vision

☐ Other: _____

OWNERSHIP & BUSINESS ENTITIES

Is your company a subsidiary of another company?

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

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

IV SPECIAL INVESTIGATIONS UNIT (SIU)

WHAT IS THE NAME OF YOUR ANTI-FRAUD UNIT IF OTHER THAN SPECIAL INVESTIGATIONS UNIT ?

WHAT IS YOUR SIU'S TOTAL NUMBER OF PERSONNEL? _____

WHAT BUSINESS UNIT OR DEPARTMENT DOES THE SIU REPORT TO/SIT WITHIN? *(Check all that apply)*

☐ Audit
☐ Clinical
☐ Compliance
☐ Finance
☐ Legal
☐ Operations
☐ Program Integrity

☐ Other: _____

(SPECIAL INVESTIGATION UNIT CONTINUED)

HOW MANY SIU EMPLOYEES FALL INTO EACH OF THE FOLLOWING CATEGORIES?

_____ Administrative	_____ Compliance staff	_____ Legal personnel
_____ Analysts	_____ Data scientists	_____ Management
_____ Auditors	_____ Investigators	_____ Medical/clinical personnel
_____ Coders	_____ IT staff	_____ Other

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. **The following membership dues rates are applicable to organizations joining after May 1, 2024.**

TOTAL ANNUAL HEALTH BENEFITS PAID	ANNUAL DUES
☐ $10 Billion or Greater	$32,000
☐ $5 Billion to $10 Billion	$26,000
☐ Less than $5 Billion	$20,000
☐ Affiliate Member	$17,000

Membership Dues to be Paid

$ **0.00**

** 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** _____

V RETURN THIS COMPLETED APPLICATION FORM AND PAYMENT TO:

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

1220 L Street NW, Suite 815
Washington, DC 20005

Phone: **202.349.7996**
Fax: **202.785.6764**

Email: **nhcaa@nhcaa.org**
Web: **www.nhcaa.org**