

Affiliate Membership Application

MEMBERSHIP IN NHCAA AS AN AFFILIATE MEMBER

Membership in NHCAA as an Affiliate Member is available to companies that are engaged in the provision of insurance products that provide for the reimbursement of medical expenses or are contingent upon health conditions (including pharmacy benefit management, workers' compensation, long-term care, disability or other property or casualty insurance products that may provide reimbursement for medical expenses) and that are not otherwise eligible for membership as a Member Organization.

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/Private Held Not-for-Profit

GEOGRAPHIC PRESENCE

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

PRODUCT LINES *(Please check all boxes below that describe your organization's insurance products)*

- Workers' Compensation Personal Injury Disability PBM Long-Term Care

Other *(Insurance products that may provide reimbursement for health care expenses)* _____

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 Compliance Legal Program Integrity
 Clinical Finance Operations

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 |

ANNUAL DUES RATE: \$17,000

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	Phone: 202.349.7984	Email: nhcaa@nhcaa.org
Washington, DC 20005	Fax: 202.785.6764	Web: www.nhcaa.org