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AHFI INVOICE

Name:		
Organization:		
Address:		
City:		
State:		
Zip Code:		
Title:		
Phone:		
E-mail:		
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I understand that by providing my mailing addresses behalf of the National Health Care Anti-Fraud ANHCAA Institute) via regular mail, e-mail, telep Signature	Association (NHCAA) or The NHCAA Institut whone and fax.	
Signature		Date
Quantity 1	Item Description AHFI Accreditation Renewal	<u>Total Charge</u> \$325.00
I certify that I am currently eligible for I have completed 48 hours of healtl programs in the past 3 years.	h care anti-fraud training, at least	24 of which were via NHCAA
Signature:	Date:	
Ple	ease return this form with payment.	
Method of Dues Payment □ Check (Make checks payable to NHCA	A) □ Credit Card □ American Express	s □ Discover □ MasterCard □ VISA
Credit Card Account #	Expiration Date	Security Code
Cardholder Name (Print)		
Billing Address		
City	State	Zip
Signature	Date	