Professional Association of Healthcare Coding Specialists

PAHCS Academy and Examination and Membership Application

PLEASE TYPE OR PRINT YOUR NAME AS YOU WOULD WANT IT TO APPEAR ON YOUR CERTIFICATE.

Name: _____PAHCS Member #:_____

CHECK ONE: Please mail related material to: ☐ Practice Address ☐ Home Address

Home Address: _____ City/State/Zip:_____

Home Telephone: _____ Home Fax: _____

Email Address _____

Education Completed: High _____ Associate _____ Bachelor _____ Master _____ Other _____

Name of Practice:_____Speciality: _____

Practice Address:_____ City/State/Zip:_____

Practice Telephone:_____ Practice Fax:_____

Certification Specialty Examination: CERTIFIED MEDICAL CODING SPECIALIST (CMCS)

SIGNATURE:_____

DATE: _____

** NOTE: Exam must be taken within one year from date of completion of classes.*

PAHCS OFFICE USE ONLY: ☐ ☐

Date _____ Approved YES NO

Approved by _____

Payment Information: *(Make checks payable to PAHCS.)*

☐ PAHCS ACADEMY (includes PAHCS membership & certification exam)

☐ In full - $1000

☐ Payment Plan - $500 down payment (must be approved by PAHCS prior to starting classes)

TOTAL AMOUNT $ _____

☐ Check ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover Name on Card: _____

Address for Card: _____

Credit Card #_____Expiration Date _____Four Digit Card Code: _____

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