## Professional Association of Healthcare Coding Specialists

# Certified Medical Coding Specialist Reciprocity Recognition Application

I hereby petition the PAHCS Credentials Committee to provide reciprocity recognition of my current national coding certification and award me the PAHCS designation of Certified Medical Coding Specialist (CMCS).

Name: _____PAHCS Member #: _____

Name of Practice: _____Specialty of Practice _____

Practice Address:_____ City/State/Zip:_____

Practice Telephone:_____ Practice FAX: _____

CHECK ONE: Please mail related material to: ☐ Practice Address ☐ Home Address (fill in below if necessary)

Home Address: _____ City/State/Zip:_____

Home Telephone: _____ Cell phone: _____

Email address: _____

**EXPERIENCE REQUIRED** - You must currently be actively employed as a Healthcare Coder, performing a scope of duties that qualify as healthcare coding for a minimum of two years. ☐ I am currently actively employed as a Healthcare Coder: ☐ YES ☐ NO
Number of years experience as a Healthcare Coder _____.

What national coding certification(s) do you currently hold?_____

**Enclose a copy of current coding certification documentation. Submitted documents will not be returned.**

I certify that I am not sanctioned by the Office of Inspector General on their Exclusions List under this name or any previous name.

**I understand that the fee is $50 to obtain the reciprocity recognition designation**.

**Special Consideration Requested?** ☐ YES ☐ NO
If you are requesting special consideration for a waiver of any of the requirements for reciprocity recognition, include sufficient justification and documentation to support your request. Special Consideration requests are individually considered.

SIGNATURE:_____

DATE: _____

Mail or fax the entire package to the address cited below.

**PAHCS OFFICE USE ONLY:**
Date:_____

Approved: ☐ YES ☐ NO
Approved by: _____
Comments:

_____**I am already a member & paying $50 Matriculation fee with a copy of my current credentials for PAHCS review.**

_____**Enclosed is $170** (regular $120 membership and $50 matriculation fee) **and a copy of my current credentials for PAHCS review.**

Type: VISA / Discover / AMEX / Mastercard

Credit Card no. _____ Exp ___/____ 3 digit card code _____

Name on Credit card _____

Address for card_____

_____I will mail my check to: PAHCS, 218 E Bearss Ave #354, Tampa, FL 33613

**PAHCS • 218 Bearss Ave #354. • Tampa, FL 33613**
**888-708-4707 • FAX 888-852-8468 • http://www.pahcs.org • e-mail: pahcs@pachcs.org**