Association for integrity in Health Care Documentation

**Certification in Denials Avoidance & Appeals Management (C-DAM)**
**Continuing Education Form**

**Date** _____ **AIHCD ID Number (If known)** _____

First Name _____ Last Name _____

Job Title _____ Company _____

Home Address _____ Work Address _____

City _____ State ____ ZIP _____ City _____ State ____ ZIP _____

Home Phone (_____) _____ Work Phone (_____) _____

E-mail Address _____

## ***CEUs for Submission***

| Program Date | Program Title | Sponsoring Organization | CEU Hours |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please mail this form and copies of all documentation supporting recertification to:**
AIHCD, P.O. Box 10530 Jackson Mississippi 39289. Forms may also be faxed to 769-208-8613
***Questions?*** Feel free to contact DocuComp LLC with any questions at support@aihcd.org or 740-968-0472.
**The recertification fee is $150.00.** ☐ I paid the recertification fee online.