

Medicare Part B Provider Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number (____) _____ Fax Number (____) _____ E-mail Address

1 or **2** (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622