

Basic Medicaid Seminar Registration Form

Basic Medicaid Workshops
April 2010 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014
Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622