Registration Form for Medicaid Recipient Appeal Process/EPSDT Workshops

Medicaid Recipient Appeal Process and EPSDT Workshops
February 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