

Health Check/EPSDT Workshops
May 2009 Seminar Registration Form
(No Fee)

Provider Name _____

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)

Please fax completed form to: 919-851-4014

Please mail completed form to:

EDS Provider Services

P.O. Box 300009

Raleigh, NC 27622