**Dental Seminars**
**September 2011 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**
**or**
**Please mail completed form to:**
**HP Provider Services**
**P.O. Box 300009**
**Raleigh, NC 27622**