

**Medicaid Recipient Appeal Process/EPSDT Workshops**  
**June 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**

**Please mail completed form to:**

**HP Provider Services**

**P.O. Box 300009**

**Raleigh, NC 27622**