

Registration Form for DME and Orthotics & Prosthetics Webinars

Webinar Registration Form for May 2012

(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)

OR

1 or **2** person(s) will attend the **morning** or **afternoon** webinar session on _____
(circle one) (circle one) (date)

Please fax completed form to: 919-851-4014

**Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622**

Or register online by utilizing the link available within the bulletin