

April 2009 Basic Medicaid Workshop Registration Form

Basic Medicaid Workshops
April 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 following sessions (check all that apply):
(circle one)

- General Session, 9:00 a.m. to 11:00 a.m.
- ADA Dental Claim/ Dental NCECSWeb Tool, 11:30 a.m. to 12:30 p.m.
- Institutional Claim, 1:00 p.m. to 2:00 p.m.
- Institutional Claim, 2:30 p.m. to 3:30 p.m.
- Professional Claim, 1:00 p.m. to 2:00 p.m.
- Professional Claim, 2:30 p.m. to 3:30 p.m.
- NCECSWeb Tool, 1:00 p.m. to 2:00 p.m.
- NCECSWeb Tool, 2:30 p.m. to 3:30 p.m.

Please specify seminar location and date:

- Lenoir
- New Bern
- Raleigh

Please fax completed form to: 919-851-4014

Please mail completed form to:

EDS Provider Services

P.O. Box 300009

Raleigh, NC 27622