

Payment Form WPS Medicare Part B

Beyond the Basics
Clarion Hotel and Conference Center
707 Fourth St.
Sioux City, IA 51101
7/29/2008

Registration: 8:30 – 9:00 AM
Seminar: 9:00 AM – 4:00 PM

Complete this form and return with payment to:
WPS – Medicare
Attn: Provider Outreach and Education
P.O. Box 7758
Madison, WI 53707

Provider Name: _____
Provider Number: _____
Address: _____

Phone Number: _____
Fax Number: _____

Attendee 1:	Attendee 2:
Name: _____	Name: _____
Title: _____	Title: _____
E-Mail: _____	E-Mail: _____

Attendee 3:
Name: _____
Title: _____
E-Mail: _____

Make Checks Payable to WPS-Medicare
Total Amount Enclosed (#X \$48.00)
Check Number _____

<p align="center">CANCELLATION/REFUND POLICY</p> <p>Due to contractual arrangements with the meeting facility, all cancellations must be received in our office no later than twenty-one (21) days prior to the scheduled event. No refunds will be issued for cancellations received after this date.</p>
