

# CAQH Training Day

## FAX REGISTRATION FORM

Please return the registration form as quickly as possible. Due to limited space, reservations are accepted on a first come first served basis. \*

### Registrant Information

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Name \_\_\_\_\_

Company/Organization \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-mail \_\_\_\_\_

### **Please select the Training Day you would like to participate:**

Sessions are held at: **1831 Chestnut Street, St. Louis, MO 63103 from 9:00 A.M. – 12:00 P.M.**

|                   |                          |                 |                          |                    |                          |
|-------------------|--------------------------|-----------------|--------------------------|--------------------|--------------------------|
| January 22, 2009  | <input type="checkbox"/> | May 28, 2009    | <input type="checkbox"/> | September 24, 2009 | <input type="checkbox"/> |
| February 26, 2009 | <input type="checkbox"/> | June 25, 2009   | <input type="checkbox"/> | October 22, 2009   | <input type="checkbox"/> |
| March 26, 2009    | <input type="checkbox"/> | July 23, 2009   | <input type="checkbox"/> | November 19, 2009  | <input type="checkbox"/> |
| April 23, 2009    | <input type="checkbox"/> | August 27, 2009 | <input type="checkbox"/> | December 17, 2009  | <input type="checkbox"/> |

Although the session is offered as a training module, you will enter provider data directly on the CAQH Online Application System (OAS). Please be sure to review the CAQH Training Checklist for a list of items needed to complete the application.

Access to the Online Application System (OAS) requires a CAQH ID#. If a number has not been assigned, please provide the following information:

*(If a CAQH ID# has already been assigned, please list provider name and CAQH ID# only)*

### Provider Information

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Name \_\_\_\_\_ Title (MD, DO, DPM, DC) \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-mail \_\_\_\_\_

CAQH ID# *(if already assigned)* \_\_\_\_\_

**Please submit the registration form to Shelley Fike via fax: 314/923-4253**

If you have additional questions or comments please call: 314/923-6706.

\* At this time we do NOT offer training to delegated or hospital based providers.