Request for Information

NICA
Post Office Box 14567
Tallahassee, FL 32317
850-488-8191 phone 850-922-5369 fax
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PARTICIPATING PHYSICIANS

To ensure proper delivery of your certificate we requesting all participating physicians fill out this form. For a group of doctors you may fill out one form and attach a list with the doctor names and licenses numbers. It is important that you also provide a contact person that we may call if we have questions regarding a doctor's account.

Thank you for your cooperation.

General Information

Name of Doctor(s): ____

____

Medical License Number(s): _____________________________________

Name of Medical Office: ____

Street Address: ____
(No PO Boxes please)

City:_______________________ State: FL Zip: ___________________

Phone: ___________________ Fax number: _________________________

Please provide a contact person that we may call or e-mail if we have questions regarding a doctor's account.

Name: ____

Phone: ___________________ Fax number: _________________________

E-mail address: ____