NTIC
Northern Tier Insurance Consortium
Health & Wellness

2020-2021 Proof of Primary Care Provider/ Primary Care Provider Declaration

I have a Primary Care Provider/have declared a Primary Care Provider.

Physician's Name: _____

Physician's Full Address: _____

_____

Physician's Phone Number: _____

Signature of Employee or Spouse: _____

Date: _____

Participant Email: _____

School: _____