Contact Me

PruittHealth PREMIER

I would like a plan representative to contact me with more information about PruittHealth Premier D-SNP. The contact request is for 12 months unless revoked.

Name: _____

Responsible Party: _____

☐ Spouse ☐ Child ☐ Sibling

☐ Public guardian/conservator ☐ Other_____

Phone Number: _____

Permission to text? ☐ Yes ☐ No

Email Address: _____

Mailing address: _____

_____

County: _____

Date: _____

☐ By checking this box, I am giving permission to the business office to provide Medicare eligibility information to the plan representative.