

## Letter of Provider Request

Request that Dr. Jeanne Perrine, OD and the Eye and Hearing Center to be an accepted provider(s) for my Health and Welfare / Employee Benefits Fund.

By signing below, I am requesting that Dr. Jeanne Perrine, OD and the Eye and Hearing Center be an accepted provider(s) for my Health and Welfare/Employee Benefits Fund.

Signed by: \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed)

Date: \_\_\_\_\_

Provider(s) Location:

Dr. Jeanne Perrine  
Eye and Hearing Center  
501 Pulliam St SW #139  
Atlanta, GA 30312  
Phone: 404-589-8517  
Fax # 404-222-0174  
website: [eyeandhearingcenter.com](http://eyeandhearingcenter.com)

Please print and fill out this form and return it to the Eye and Hearing Center either by mail, fax or in person to have your request processed.