REQUEST FOR PROFESSIONAL LIABILITY
RECEIPT FOR REIMBURSEMENT

Please Print

MEMBER NAME: ____

CERTIFICATE # OR SS#: ____

MAILING ADDRESS: ____

____

WORK PHONE: ____

FAX # OR E-MAIL: ____

PERIOD REQUESTED

PLEASE NOTE: Receipts will only be prepared for periods already fully paid. In addition, we will provide only one receipt per 12 month period free of charge. Additional receipts will be prepared at a prepaid cost of $5.00. Incomplete request forms will not be processed.

SPECIFY DATE RANGE

From Date:______________________ Through Date:______________________

Signature:____ Date:______________________

PLEASE ALLOW 3-5 DAYS FOR YOUR REQUEST TO BE PROCESSED

MAIL THE FULLY COMPLETED REQUEST FORM TO:

Mass Benefits Consultants, Inc.
PO Box 828
Annandale, VA 22003-0828

OR FAX TO: 703-642-2240