Updated 10.2023

DISBURSEMENT REQUEST FORM

Beneficiary Name: _____ Date:_____

Account Number: WTC_____

Please check all current benefits:

☐ Medicaid ☐ Medicare ☐ SSI ☐ SSDI ☐ SSA (Retirement)

☐ Housing ☐ Supplemental Medical Ins./Drug Coverage ☐Other: _____

☐ **PLAN has been provided updated benefit documentation, if applicable.**

Date of Receipt/Invoice	Vendor/Provider/Place of Purchase	Item(s)/Service(s) Purchased (Please be as specific as possible)	Receipt/Invoice Total
		Total Amount Requested:	

☐ **All receipts/invoices/bills are ITEMIZED and COMPLETE and attached**. (Do not write on receipts/invoices.)

Please clearly print all information below:

_____

Make Check Payable to NAME ADDRESS CITY/STATE/ZIP CODE

_____

Mail to: (if different from above)

☐ **Please check box if address has changed since previous disbursement.**

Request made by:_____Tel. # _____

Email: _____

Relationship to beneficiary:____POA ____Guardian ☐Other (explain): _____

I hereby attest, under the pains and penalties of perjury, that the purchase(s) associated with this request were made for the ***sole benefit*** of the Trust Beneficiary.

_____ _____

Signature Date

Submit form and receipts/invoices/bills via:

Email: billing@planofma-ri.org

Mail: PLAN of MA & RI
Two Adams Place, Suite 110
Quincy, MA 02169

Fax: 617-795-0589

If there are questions or concerns regarding this request, PLAN staff will contact you.
PLAN strives to mail checks 7-10 business days from receipt of the request.