Note: This form should be completed and returned to Everest. Maintain a copy for your records.

# EMPLOYER VERIFICATION
# Everest Medical Provider Network

This is to confirm that we **posted** the required MPN information on _____
(Date Posted)

_____ _____
(Policy Number) (Policy Period)

_____ _____
(Employer Name) (Employer Telephone Number)

_____ _____
(Employer Address –*street, city, state, zip*) (Employer Contact Name)

**Submit** this form:

by mail to: Everest National Insurance Company
Attn: MPN Ombudsman
P.O. Box 69
Orange, CA 92856

or fax to: (714) 371-9675

or e-mail to: EverestMPN@everestre.com

For questions please call the Everest MPN Ombudsman at (800) 608-9822