

Request for Reimbursement

Quincy Public Schools

Participant Identification (Please print or type)

Participant Name: _____ Social Security Number: _____

1. MEDICAL EXPENSE REIMBURSEMENT

For expenses that are covered by your insurance, attach copies (*photocopies acceptable*) of the Explanation of Benefits (EOB) or the Provider's bill to verify the amount paid by insurance. (*You may not be reimbursed through the Cafeteria plan for expenses that are covered by your insurance.*)

For all other reimbursable expenses, copies of all bills (*photocopies acceptable*) must be attached which show: Name & Address of the Provider, *Name of Patient*, Reason for the Charges, Date & Amount of the Charges. **Please Note: Canceled checks, charge card receipts, "previous balance", "received on account" and "balance due" statements are not acceptable as documentation of an expense.**

IMPORTANT: TO BE ELIGIBLE, ALL EXPENSES MUST BE MEDICALLY NECESSARY, I.E., TO TREAT AN ILLNESS OR DISEASE, AND NOT FOR COSMETIC PURPOSES.

Date of Service	Physician or Other Provider	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
Total Amount Requested		\$ _____

2. DEPENDENT CARE EXPENSE REIMBURSEMENT

You must attach receipts showing amount charged for dependent care, time period covered for expense, provider signature, federal tax ID# or SSN of provider.

Services Provided	Day Care Provider	Amount
From _____ to _____	_____	\$ _____
From _____ to _____	_____	\$ _____
From _____ to _____	_____	\$ _____
From _____ to _____	_____	\$ _____
Total Amount Requested		\$ _____

Statement by Participant

To the best of my knowledge and belief, the statements in this Request are complete and true. I am claiming reimbursement only for expenses incurred during the Plan Year. I certify that these expenses have not been, nor will be, reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Participant Signature

Date