CITY OF O'FALLON – page 2 attachment
CAFETERIA PLAN REQUEST FOR REIMBURSEMENT

Employee Name (please print): _____

UNREIMBURSED MEDICAL - continued

List Each Receipt Separately

A Patient Name	B Provider Name	C Description of Service	D Dates Service Provided	E Requested Amount of Reimbursement	Office Use ONLY

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are not acceptable.

NOTE: Place signature on page 1