**CITY OF JACKSONVILLE**

CITY HALL, ST. JAMES BUILDING
117 WEST DUVAL STREET
JACKSONVILLE, FL 32202

# REIMBURSEMENT REQUEST FORM
# FLORIDA STATUTE §112.1816

**Employee Name: _____ Date: _____**

Pursuant to Florida Statute §112.1816, I am seeking reimbursement from the City of Jacksonville for the following out-of-pocket deductible costs, copay costs, and/or co-insurance costs which I have incurred due to the treatment of cancer.

| | | |
|---|---|---|
| $_____ | _____ | _____ |
| Cost | Date Incurred | Type of cost (out-of-pocket; copay; or co-insurance) |
| $_____ | _____ | _____ |
| Cost | Date Incurred | Type of cost (out-of-pocket; copay; or co-insurance) |
| $_____ | _____ | _____ |
| Cost | Date Incurred | Type of cost (out-of-pocket; copay; or co-insurance) |
| $_____ | _____ | _____ |
| Cost | Date Incurred | Type of cost (out-of-pocket; copay; or co-insurance) |
| $_____ | _____ | _____ |
| Cost | Date Incurred | Type of cost (out-of-pocket; copay; or co-insurance) |

**Please attach a copy of your Explanation of Benefits and proof of payment receipt for each of the above charges.**

**I hereby certify that the costs and expenses listed above are true and accurate, as shown in the attached documentation, and that I have not received nor will not receive payment or reimbursement towards any of those costs/expenses from any other source.**

_____ _____

**Applicant Signature** **Date**