

SAMPLE



MEDICAL EXPENSE REPORT

1. NAME OF VETERAN (First, middle, last) JOSEPH A VETERAN		2. VA FILE NUMBER 123 456789
3A. NAME AND ADDRESS OF CLAIMANT 123 main st #1 YOUR TOWN WI 53201	3B. CHANGE OF ADDRESS (Check box if address in Item 3A is different from last address furnished to VA) <input type="checkbox"/>	3C. E-MAIL ADDRESS (If applicable)
4. VETERAN'S SOCIAL SECURITY NO. 123 456789		

NOTE: Family medical expenses actually paid by you may be deductible from your income. Report the actual amount of unreimbursed medical expenses you paid for yourself or relatives who are members of your household. Do not report any expenses you did not pay or expenses for which you were or will be reimbursed. Any expenses reasonably related to medical or dental care may be allowed as medical expenses. Examples of allowable medical expenses include the following: hospital expenses, office visits, drugs and medicines, eyeglasses, dental fees, medical insurance premiums (including the Medicare deduction), hearing aids, nursing home fees, home health services, and transportation for medical purposes (28.5 cents per mile, plus parking and tolls or fares for taxis, buses, etc.). If you are not sure whether a particular expense can be allowed, furnish a complete description of the purpose of the payment. We will let you know if an expense cannot be allowed. If more space is needed, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

You may be asked to verify the amounts you actually paid, so keep all receipts or other documentation of payments for at least 3 years after we make a decision on your medical expense claim. If you are unable to provide documentation of payments for at least 3 years after we make a decision of your medical expense claim. If you are unable to provide documentation of the claimed medical expenses when asked to do so by VA, your benefits will be retroactively reduced or terminated.

Report medical expenses for the period **01-01-09** thru **12-31-09** If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates your medical expense report should cover.

5. ITEMIZATION OF MEDICAL EXPENSES

A. PURPOSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID BY YOU	C. DATE PAID (Mo Day Yr)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child)
MEDICARE (PART B)	1,580.00	1/09 12/09	Medicare	self
PRIVATE MEDICAL INSURANCE	3,500.00	1/09 12/09	BCBS	self/spouse
PRESCRIPTIONS	580.00	1/09 12/09	WALGREEN'S	self
PRESCRIPTIONS	750.00	1/09 12/09	WALGREENS	SPOUSE
NURSING HOME	15,000.00	1/09 12/09	MORNING GLORY	spouse
NURSING HOME	15,000.00	1/09 12/09	MORNING GLORY	self
OTC'S	1,000	1/09 12/09	WALGREENS	self/spouse
MILEAGE / 1,500 MILES x 28.5¢	427.50	1/09 6/09	SPOUSE	SELF
MILEAGE / —	1,500.00	7/09 12/09	Elder Transit	self/spouse
SITTER FEES	2,000.00	1/09 12/09	VETS HOME CARE	self
Life Line Emergency	50.00	1/09 12/09	Rory Emergency Service	self/spouse
Ambulance service	150.00	4/25/09	Bell South	self
Dr. VISITS	750.00	1/09 12/09	Dr. Hannah	self/spouse
Dental visits	1,750.00	1/09 12/09	Dr. Franks	self/spouse

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

