OMB Approved No. 2900-0161
Respondent Burden: 30 minutes

Department of Veterans Affairs

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN *(First,middle,last)*		2. VA FILE NUMBER
3A. NAME AND ADDRESS OF CLAIMANT	3B. CHANGE OF ADDRESS *(Check box if address in Item 3A is different from last address furnished to VA)* ☐	4. VETERAN'S SOCIAL SECURITY NO.

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 (20 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 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 thru . 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)			SOCIAL SECURITY	
PRIVATE MEDICAL INSURANCE				

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

5. ITEMIZATION OF MEDICAL EXPENSES (*Continued)*

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)

I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

6A. DAYTIME TELEPHONE NO. *(Include Area Code)*	6B. EVENING TELEPHONE NO. *(Including Area Code)*

7A. SIGNATURE OF CLAIMANT *(Do NOT print)*	7B. DATE

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

Privacy Act Notice: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22, Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits under the law. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

Respondent Burden: We need this information to determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.