Department of Veterans Affairs

# INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you at a higher rate if you identify expenses VA considers allowable. Medical and dental expenses paid by you may be deductible from the income VA counts when determining your benefit entitlement.

In Items 20 and 21 below, identify any medical or dental expenses that you paid for a member of your household (self, spouse, child, etc.) for which you were not reimbursed. Below are examples of expenses you should include, if applicable:

- Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Nursing home costs
- Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor, or other medical facility
- Monthly Medicare deduction

## IMPORTANT NOTES

- Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly notify the VA office handling your claim.
- If you are not sure whether a particular expense can be allowed, furnish a complete description of the purposes of the payment. We will let you know if an expense cannot be allowed.
- You may be asked to verify the amounts you actually paid, so keep all receipts or other documentation of payments for at lease 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 may be retroactively reduced or terminated.
- If more space is needed to report expenses, 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.

**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, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, 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 provided under 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.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 09/30/2017

Department of Veterans Affairs

FOR VA USE ONLY

# MEDICAL EXPENSE REPORT

| 1. FIRST NAME OF VETERAN | 2. MIDDLE NAME OF VETERAN | 3. LAST NAME OF VETERAN | 4. SUFFIX NAME OF VETERAN |
|---|---|---|---|
| | | | |

| 5. VETERAN'S SOCIAL SECURITY NO. | 6. VA FILE NUMBER |
|---|---|
| | |

| 7. FIRST NAME OF CLAIMANT | 8. MIDDLE NAME OF CLAIMANT | 9. LAST NAME OF CLAIMANT | 10. SUFFIX NAME OF CLAIMANT |
|---|---|---|---|
| | | | |

| 11. STREET ADDRESS OF CLAIMANT | 12. APT. NO. |
|---|---|
| | |

| 13. CITY | 14. STATE | 15. ZIP CODE |
|---|---|---|
| | | |

| 16. DAYTIME TELEPHONE NO. OF CLAIMANT *(Include Area Code)* | 17. EVENING TELEPHONE NO. OF CLAIMANT *(Include Area Code)* |
|---|---|
| | |

| 18. CHANGE OF ADDRESS *(Check box if address in Items 11-15 is different from last address furnished to VA)* ☐ | 19. EMAIL ADDRESS OF CLAIMANT *(If applicable)* |
|---|---|
| | |

**20. ITEMIZATION OF EXPENSES RELATED TO TRANSPORTATION FOR MEDICAL PURPOSES**

Report expenses related to transportation to a hospital, doctor, or other medical facility that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

NOTE: If you claim miles traveled to a medical facility in a personal conveyance (car, motorcycle, other), VA will calculate the allowable expense amount based on the current mileage rate (41.5 cents per mile).

| A. MEDICAL FACILITY TO WHICH YOU TRAVELED | B. TOTAL ROUNDTRIP MILES TRAVELED *(Personal conveyance only)* | C. AMOUNT PAID BY YOU *(Taxi, public transportation fares, tolls, parking fees, etc.)* | D. DATE PAID *(Month/Day/Year)* | E. FOR WHOM PAID *(Self, spouse, child)* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**IMPORTANT: Be sure to sign this form in Item 22A on the reverse side. Unsigned reports will be returned.**



*(Continued on Reverse)*

## 21. ITEMIZATION OF MEDICAL EXPENSES

Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

| A. MEDICAL EXPENSE *(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)* | B. AMOUNT PAID BY YOU | C. DATE PAID *(Month/Day/Year)* | D. NAME OF PROVIDER *(Name of doctor, dentist, hospital, lab, etc.)* | E. FOR WHOM PAID *(Self, spouse, child)* |
|---|---|---|---|---|
| MEDICARE (PART B) | | | | |
| MEDICARE (PART D) | | | | |
| PRIVATE MEDICAL INSURANCE | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| 22A. SIGNATURE OF CLAIMANT *(Do NOT print)* | 22B. 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.