Department of Veterans Affair	rs								
	MEDICAL EX	(PENSE	REPO	RT					
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)		3C. E-MAIL ADDRESS (If applicable)				
4. VETERAN'S SOCIAL SECURITY NO.									
NOTE: Family medical expenses actually paid by you paid for yourself or relatives who are members of your reimbursed. Any expenses reasonably related to medic the following: hospital expenses, office visits, drugs an hearing aids, nursing home fees, home health services buses, etc.). If you are not sure whether a particular exknow if an expense cannot be allowed. If more space i write your VA file number on any attachments. You may be asked to verify the amounts you actually pon your medical expense claim. If you are unable to proclaim. If you are unable to provide documentation of the	household. Do not rep cal or dental care may id medicines, eyeglass s, and transportation fo xpense can be allowed is needed, attach a sep paid, so keep all receip rovide documentation of	port any expended as a lowed as allowed as allowed as as a lower and a lower a	ses you de medical es, medical es, medical es coses (28 nplete des f paper wi	did not pay or expenses expenses. Examples of I insurance premiums of 5 cents per mile, plus excription of the purpose ith columns correspondent on of payments for at 1 3 years after we make	s for which of allowable (including t parking an e of the pay ding to thos east 3 year a decision	you were or will be a medical expenses include he Medicare deduction), d tolls or fares for taxis, yment. We will let you se on this form. Be sure to a safter we make a decision of your medical expense			
terminated.	e claimed medicai exp	enses when a	iskea to u	0 S0 by VA, your bene	ilts wiii de i	retroactively reduced of			
Report medical expenses for the period refer to the accompanying letter or Eligibility Verificatio	thru on Report for the dates	your medical		no dates appear on the report should cover.	is line,				
5. ITEMIZATION OF MEDICAL EXPENSES									
A. PURPOSE (Physician or Hospital Charges Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID BY YOU	C. DATE P (Mo/Day/Y		(Name of doctor dentist		E. FOR WHOM PAID (Self, spouse, child)			
MEDICARE (PART B) PRIVATE MEDICAL INSURANCE									
		_ 							
IMPORTANT: Be sure to sign this	s form in Item 7A	on the rev	erse si	ide. Unsigned re	ports wi	Il 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. (Include 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, 58VA21/22/28 Compensation, Pension, Education, and Vocational 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 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.