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

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. E-MAIL 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.