Your Name:_____ Year of Expenses: _____

Medical Expense Worksheet

Deductible only if net cost exceeds 10% of Adjusted Gross Income (AGI)

Note: Do not include amounts paid for or reimbursed by insurance, or health insurance premiums paid with pre-tax income, or paid from an FSA or HSA

	Yes	No
Did you pay medical expenses for a person you cannot claim as a dependent	☐	☐
Did your employer pay any part of your health Insurance	☐	☐

Insurance (Only after-tax payments)

Health & Hospitilization Insurance Premiums (Include Medicare Supplemental Plans).....$_____

Dental Insurance.....$_____

Vision Insurance .....$_____

Long-Term Care insurance Premiums/Taxpayer.....$_____

Long-Term Care insurance Premiums/Spouse .....$_____

Medicare Insurance Premiums Paid (Parts B, C & D from Form SSA-1099).....$_____

Doctor and Dentists

Doctors, Hospitals, & Nurses.....$_____

Dentists & Orthodontists.....$_____

Glasses, Contact Lenses, Eye Exams, Laser Eyes Surgery.....$_____

Nursing or Long-Term Care Facility.....$_____

Other

Prescriptions (RX).....$_____

Medical Transportation (Taxi, Bus, Ambulance, Etc.).....$_____

Medical miles driven during the year to obtain medical care or supplies .....# of miles_____ _____

Lodging while obtaining medical treatment – *Limited to $50 per night, per person*.....$_____

Home improvements made for medical purposes_____$_____

Parking Fees_____$_____

I certify that the above information is true and accurate, **and** I have receipts to confirm proof of payments.

_____ _____

Prepared by **Date**

Veritas CPA Group LLC
3960 Brown Park Dr. Suite C Hilliard, OH 43026
Phone: (614) 771-7700 Fax: (614) 771-7774
www.veritascpas.com