

Your Name: _____ Year of Expenses: _____

Medical Expense Worksheet

Deductible only if net cost exceeds 7.5% 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.

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)

Hospitalization and Health Insurance Premiums (Include Medicare Supplemental Plans)..... \$ _____

Medicare Insurance Premiums Paid (Form SSA-1099)..... \$ _____

Long-Term Care insurance Premiums..... \$ _____

Vision Insurance \$ _____

Dental Insurance..... \$ _____

Long-Term Care Insurance Premiums..... \$ _____

Doctor and Dentists

Dentists and Orthodontists..... \$ _____

Hospitals, Nurses, Ambulance..... \$ _____

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

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

Other

Medical Transportation (taxi, bus, ambulance, etc.)..... \$ _____

Parking Fees..... \$ _____

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..... \$ _____

_____ \$ _____

_____ \$ _____

I certify that the above information is accurate and I have receipts to confirm proof of payments :

Prepared by _____

Date _____