MEDICAL EXPENSE STATEMENT

List non reimbursed amounts you paid in 202__ for qualified medical expenses.

CLAIMANT'S NAME_____ **COUNTY** _____

ADDRESS _____

Include amounts paid in 202__ for: Medical Insurance*, Doctors, Prescription Drugs, Hospitals, Ambulance, Nursing Homes, MedicalLodging, and other qualified medical expenses**

WHO WAS THE PAYMENT MADE TO?	TYPE OF SERVICE	AMOUNT PAID IN 202__
	TOTAL	

WHO WAS THE PAYMENT MADE TO?	TYPE OF SERVICE	AMOUNT PAID IN 202_
	TOTAL	

MEDICAL MILEAGE:

January 1, 202__ to December 31, 202__				
From	**To**	**Miles**	**X. ___Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
From	**To**	**Miles**	**X .___ Per Mile**	
TOTAL FROM FRONT				
TOTAL FROM BACK				
TOTAL REIMBURSEMENT RECEIVED BY YOU IN 202__				**( )**
GRAND TOTAL – Transfer amount to line 13 of the property tax reduction application				

***Include only insurance premiums for policies that cover medical care. Do not include pre-tax medical insurance premiums or other insurance premiums that have already reduced your income. Do not include premiums for "income replacement" policies. Federal limits apply for long term care insurance premiums. ** For a full list of qualified medical expenses refer to IRS Publication 502.**

I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE DOCUMENTATION FROM THE PROVIDER OF THE SERVICE FOR EXPENSES CLAIMED ON LINE 13 OF MY PROPERTY TAX REDUCTION APPLICATION. ☐ **_____ *(initials)***

UNDER PENALTY OF PERJURY, I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED HEREIN IS TRUE, CORRECT, AND COMPLETE.

_____ _____

SIGNATURE OF CLAIMANT OR REPRESENTATIVE DATE