

**Form A**

**Medical Expenses**

**MEDICAL EXPENSES**

Prescription medication \$ \_\_\_\_\_

Health Insurance Premium \$ \_\_\_\_\_

Long-Term Care Taxpayer \$ \_\_\_\_\_ Insurance Co Name \_\_\_\_\_ Policy # \_\_\_\_\_

Long-Term Care Spouse \$ \_\_\_\_\_ Insurance Co Name \_\_\_\_\_ Policy # \_\_\_\_\_

Long-Term Care Dependent \$ \_\_\_\_\_ Insurance Co Name \_\_\_\_\_ Policy # \_\_\_\_\_

Fees for Doctors, Dentist etc \$ \_\_\_\_\_

Fees for hospitals, clinics etc \$ \_\_\_\_\_

Lab and X-Ray fees \$ \_\_\_\_\_

Eyeglasses and contact lenses \$ \_\_\_\_\_

Equipment and supplies \$ \_\_\_\_\_

Medical Transportation \$ \_\_\_\_\_

Miles driven for medical \$ \_\_\_\_\_

Lodging for medical care \$ \_\_\_\_\_

Other medical and dental \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_