

Medical Expenses from _____ / _____ to _____ / _____

Taxpayer's Name: _____ SIN # _____

Date	Total	Reimbursed By Insurance	Net	Patient	Practitioner	Treatment
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
_____	_____	_____	\$ _____	_____	_____	_____
Total Paid by Taxpayer:			\$ _____			

