[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Recipient Name or Insurance Company]
[Department Name]
[Address]

Subject: Itemized End of Year Medical Expense Summary for [Year]

To Whom It May Concern,

Please find below an itemized summary of medical expenses incurred by [Patient Name] for the calendar year [Year]. This summary is provided for [tax purposes / reimbursement / record keeping].

Date of Service	Provider/Facility Name	Description of Service	Total Amount Billed	Amount Paid Out-of-Pocket
[MM/DD/YYYY]	[Provider Name]	[e.g., Office Visit]	$[0.00]	$[0.00]
[MM/DD/YYYY]	[Pharmacy Name]	[e.g., Prescription Medication]	$[0.00]	$[0.00]
			Total Out-of-Pocket Expenses:	**$[0.00]**

I have attached the corresponding receipts and Explanations of Benefits (EOB) for your verification. Please contact me at [Phone Number] if you require any further documentation or clarification.

Sincerely,

[Your Signature]

[Your Printed Name]