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

[Date]

To: [Recipient Name/Organization Name]
[Address]
[City, State, Zip Code]

Subject: Summary of Out-of-Pocket Medical Expenses for [Year]

Dear [Name/Tax Preparer/Insurance Provider],

Please find below a summary of my out-of-pocket medical expenses for the calendar year [Year]. This list includes payments made for healthcare services, prescriptions, and medical supplies that were not covered or reimbursed by insurance.

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

I have retained all original receipts and statements corresponding to the items listed above should you require further verification. Please contact me at [Phone Number] if you have any questions regarding this summary.

Sincerely,

[Your Signature]

[Your Printed Name]