

# ELIGIBLE EXPENSE LISTING



## HEALTH CARE EXPENSES

Acupuncture	Hospital Services	Physician Office Visits
Ambulance	Immunizations	Pregnancy Test Kit
Artificial Limb/Teeth	Infertility Treatment	Prescription Drugs
Bandages	Insulin and Diabetic supplies	Prosthesis
Birth Control/Contraceptives	Laboratory/Diagnostic Fees	Psychiatric Care
Body Scan	Lactation Expenses	Psychoanalysis
Braille Books/Magazines	Language training (dyslexia)	Psychologist Fees
Breast Pumps/Supplies	Laser Eye Surgery	Reading Glasses
Breast Reconstruction	Learning Disability	Sales Tax, Shipping, Handling fees for medical supplies
Chiropractors	Massage Therapy*	Stop-Smoking Program
Concierge Medical Care (amount billed for service and not monthly fee)	Medical Conferences*	Smoking Cessation prescriptions
Contact Lenses, solutions/cleaners	Medicines	Speech Therapy
Copays, Coinsurance, Deductibles	Midwife	Substance Abuse Treatment
Dental Care	Mileage incurred to seek health care	Sunglasses (prescription)
Diagnostic Services/Devices	Nursing Services	Surgery
Durable Medical Equipment (crutches, canes, walkers, wheelchairs)	OB/GYN Fees	Sterilization
Dermatologist	Occlusal Guards	Telephone/TV for disability or impairment
Eye Exams and Eyeglasses (prescription)	Operations	Therapy for medical condition
Fertility Enhancement	Optometrist	Transplants
Guide Dog or other service animal	Organ Donors	Trips/Travel Expense to seek health care
Hearing exams, aids/devices and batteries	Orthodontia	Vasectomy
	Orthotics	Vision Care
	Osteopath	Vision Correction Surgery
	Over-the-Counter Drugs*	Weight-Loss Program for medical condition*
	Over-the-Counter health care products	Wigs*
	Oxygen	X-Rays
	Physical Examination	
	Physical Therapy	

## DEPENDENT CARE EXPENSES

- Adult/Elder/Senior Day Care Center
- Au pair or Nanny
- Babysitting
- Before- or after-school care
- Child Day Care Center
- Nursery school or Preschool
- Registration Fees (after service provided)
- Sick Child Care
- Summer Day Camp

# EXPENSE WORKSHEET



## Health Care Worksheet

<b>Medical</b>	<b>Amount</b>
Copays, Deductibles	\$ _____
Physician Visits	\$ _____
Prescriptions	\$ _____
Over-the-Counter Items	\$ _____
Diabetic Supplies	\$ _____
Chiropractic Treatments	\$ _____
Mileage	\$ _____

<b>Dental</b>	
Fillings	\$ _____
Crowns	\$ _____
Bridges	\$ _____
Dentures & cleaners	\$ _____
Oral Surgery	\$ _____
Orthodontia	\$ _____
Mileage	\$ _____

<b>Vision/Hearing</b>	
Prescription Eyeglasses	\$ _____
Prescription Sunglasses	\$ _____
Reading Glasses	\$ _____
Contact Lenses	\$ _____
Contact Cleaners	\$ _____
Laser Eye Surgery	\$ _____
Hearing Exams	\$ _____
Hearing Aids & Batteries	\$ _____
Mileage	\$ _____

**TOTAL** \$ \_\_\_\_\_

## Dependent Care Worksheet

<b>Month</b>	<b>Amount</b>
Month 1	\$ _____
Month 2	\$ _____
Month 3	\$ _____
Month 4	\$ _____
Month 5	\$ _____
Month 6	\$ _____
Month 7	\$ _____
Month 8	\$ _____
Month 9	\$ _____
Month 10	\$ _____
Month 11	\$ _____
Month 12	\$ _____

**TOTAL** \$ \_\_\_\_\_



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