CAPROCK
HEALTHPLANS
A Division of Caprock Health Group

MEDICAL REIMBURSEMENT ACCOUNT
QUALIFYING EXPENSE WORKSHEET

To gain maximum benefit from your flexible spending account(s), you should accurately budget your unreimbursed medical expenses. ***Only expenses that you know you will incur during the Plan Year should be included in this program.*** *This worksheet is a guide to assist you with common items, but does not include all types of expenses that may be eligible.*

QUALIFYING EXPENSE	**ESTIMATED ANNUAL EXPENSE**		
	YOU	**SPOUSE**	**DEPENDENT(S)**
Medical Expenses:			
Medical Doctor's Fees/Co-Payments	$_____	$_____	$_____
Annual Physical Examinations	$_____	$_____	$_____
Prescription Drugs	$_____	$_____	$_____
X-rays and Lab Fees	$_____	$_____	$_____
Hospital Services	$_____	$_____	$_____
Chiropractors and Acupuncturists	$_____	$_____	$_____
Surgery	$_____	$_____	$_____
Ambulance Service	$_____	$_____	$_____
Psychiatrists or Psychologists	$_____	$_____	$_____
Visions Expenses:			
Eye Exams	$_____	$_____	$_____
Glasses, Contact Lenses, Solutions	$_____	$_____	$_____
Lasik Eye Surgery	$_____	$_____	$_____
Dental Expenses:			
Deductible/Co-pay	$_____	$_____	$_____
Teeth Cleaning, X-rays, Fillings	$_____	$_____	$_____
Crowns, Root Canals	$_____	$_____	$_____
Braces	$_____	$_____	$_____
Dentures, Bridges	$_____	$_____	$_____
Hearing Expenses:			
Exams, Hearing Aids	$_____	$_____	$_____
Other Eligible Expenses:	$_____	$_____	$_____

TOTAL ANNUAL MEDICALLY RELATED EXPENSES $_____

PAY PERIOD ELECTION
(Divide total annual expenses by number of pay periods per year) $_____