OFFICE OF
FINANCIAL AID
UNIVERSITY OF MICHIGAN

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MEDICAL/DENTAL EXPENSE QUESTIONNAIRE 2024–2025

This information is required to process your application for financial aid for the 2024–2025 academic year. Complete this form and return it to the address above as soon as possible. All submitted information must include the student's U-M ID number.

Information provided on this form will be used for Office of Financial Aid business ONLY.

Information will not be disclosed to anyone outside the Office of Financial Aid.

Student's name: Last First M.I. U-M ID number (8 digits)

You have requested that we review your high unreimbursed medical/dental payments. So that we can consider these payments, we ask that you provide the following information and documentation. Please note that the federal methodology used to calculate your financial aid allows for a certain amount of medical/dental payments already. Contact our office to determine if completing this form would change your eligibility for financial aid.

EXPENSE SUMMARY

- Speak with an aid administrator for details on which tax year's information to use when completing this form.
- List the total amount of family medical and/or dental payments that will not be reimbursed by a health care insurance plan.
- Attach supporting documentation for listed expenses (such as bills already paid or a summary statement from a doctor, dentist, or pharmacy, itemizing payments made) and attach signed and dated copies of the appropriate year's federal tax returns including all schedules (if not already submitted to our office).
- We cannot consider any expenses that are not documented. (Do not submit Estimate of Benefit Forms.)
- Documentation is being submitted for the following period (cannot exceed 12 months):

  Start: _____ End: _____

Medical/Dental Expenses (ATTACH REQUIRED DOCUMENTS)	Amount Already Paid by Family	Amount Paid by Insurance	Total Cost
Doctor's visits, tests, outpatient care (bills, statements showing amounts not paid by insurance)	$	$	$
Prescriptions (receipts) or summary statement from pharmacy	$	$	$
Hospitalization (hospital statements)	$	$	$
Ongoing therapy — attach a separate sheet explaining the expense (bills, statement from therapist)	$	$	$
Eye glasses, contact lenses (bills, receipts)	$	$	$
Dental exams, routine care (bills, statement of account from dentist office)	$	$	$
Orthodontic or specialized dental treatment (bills, statement of account)	$	$	$
Monthly out-of-pocket insurance premium(s) paid by family **(Do not include pre-tax premiums)**	$	$	$
Other — attach separate sheet explaining the expense (document the cost)	$	$	$
Total	$	$	$

Student's signature (typed signatures are acceptable) Date

Parent/guardian signature (typed signatures are acceptable) Date