
# Cost Differential Determination Form

This must be accompanied with a completed Medical Determination Form – www.taxsaverplan.com.

You may submit this completed form to TaxSaver Plan via facsimile at 214-528-8122.

_____
Patient Name

_____
Participant Name

_____
Participant Employer

_____
Participant Social Security Number

Please answer the following questions. Please print legibly to expedite processing.

1. List the total amount of the expenditure / expense.
$_____

2. List the cost differential between standard average like item expense and the expense prescribed for specialized use if applicable (this amount must be reasonable with our findings upon review).

Standard average cost $_____
Special use cost -$_____
Difference amount $_____

3. List the percentage of use that will be for the patient in relation to other household members.
____% for patient use; ____% for other household member use

4. List the name and detailed description of the expense.
_____
_____

I certify that the above information is true to my knowledge.

_____ _____
**Participant Signature** **Date**