VAN BUREN COUNTY COURTS • STATE OF MICHIGAN •	**DEMAND FOR HEALTH CARE EXPENSES**	**DOCKET NO.**

Court Address
219 E. Paw Paw Street, Paw Paw, MI 49079

Court Telephone No.
269-657-7734

INSTRUCTIONS FOR DEMAND FOR HEALTH CARE EXPENSES

Before using this form, you must:

1. provide the other parent with copies of all bills,
2. provide the other parent with copies of all related insurance statements, and
3. try to obtain the reimbursement directly from the other parent.

You must do this within 28 days of receiving final word from the insurance company as to whether or not health care expenses are covered by the health care coverage plan.

If the other parent fails to respond to your request or the response is not satisfactory then you should use the attached form, Demand for Health Care Expenses, to request assistance from the Friend of the Court (FOC) Office.

DO NOT send copies of the bills or insurance statements to the FOC Office. Send the attached form **ONLY**. Do bring bills and insurance statements to the FOC Office in the event of a meeting or hearing regarding medical expenses.

A. Complete the following items for each bill on the attached sheet:
B. The date the service was provided
C. The name of the child receiving the service
D. The name of the service provider
E. The nature of the service (well-child visit, teeth cleaning, urgent care, etc.)
F. The cost of the service
G. The amount paid by insurance
H. Any amounts that are discounted by the service provider
I. The amount of unreimbursed health-care expenses. This is equal to the cost of the service less any amounts paid by insurance, less any amounts discounted by the service provider.

The Court will not enforce any health-care expenses that are over one year old from the date of service.

Health-care expenses are generally added to the support account as a past due amount of support and are collected similarly to child support arrearages.

Review your Court order before submitting your Demand for Health Care Expenses. Do you have to exceed a minimum amount of expenses before asking for reimbursement?

DEMAND FOR HEALTH CARE EXPENSES

Plaintiff Name: _____

Docket Number: _____

Defendant Name: _____

SUMMARY OF MEDICAL EXPENSES							
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Date of Service mm/dd/yy	Name of Child Receiving Treatment	Name of Medical Provider	Nature of Treatment	Total Cost	Amount Paid by Insurance	Insurance Discount/ Provider	Uninsured Expense (Column E less Columns F and G)
						Total	

DO NOT WRITE IN THIS BOX - FOR FRIEND OF THE COURT USE ONLY

Total medical cost not paid by insurance: **$** _____

Less annual amount of Ordinary Health Care expenses: **$** _____

Balance eligible for reimbursement: **$** _____

Percentage to be paid by Plaintiff / Defendant: **x** _____ **%**

Total amount due Plaintiff / Defendant: **$** _____

I declare that the above information of health care expenses for the minor child are true amounts to the best of my information, knowledge, and belief. I have previously requested payment from the other parent and provided that party with copies of the bill(s) and insurance statement(s).

_____ _____

Date Plaintiff / Defendant (Circle One)