



INSTRUCTIONS FOR DEMAND FOR HEALTH CARE EXPENSES

Court Address
203 S Niles Street, Paw Paw, MI 49079

Court Telephone No.
269-657-7734

Before submitting this form to the Friend of the Court (FOC), you must first:

1. Provide the other parent with copies of:
 - All medical bills; and
 - The Request for Health Care Expense Payment form.
2. Include copies of any related insurance statements.
3. Try to get reimbursement directly from the other parent.

You must complete the steps above within 28 days after receiving the final response from your insurance company about whether the expense is covered.

If the other parent does not respond or their response is unsatisfactory, you may then submit the Demand for Health Care Expenses form to the Friend of the Court.

When submitting your demand:

- Send copies of your bills and insurance statements to the FOG.
- Keep the originals in case a hearing is scheduled about these expenses.

How to Complete the Attached Sheet

Required Information	Description
Date of Service	The date the child received care
Child's Name	Name of the child who received the service
Provider's Name	Doctor, dentist, clinic, or other provider
Type of Service	Example: well-child visit, dental cleaning, urgent care
Total Cost	The full cost charged by the provider
Insurance Payment	The amount your insurance paid
Discounts	Any discounts or write-offs given by the provider
Unreimbursed Amount	The total cost minus insurance payments and discounts

Important Reminders

- The Court will not enforce any health care expenses that are more than one year old from the date of service.
- Approved health care expenses are added to your support account and collected like child support arrears.
- Review your court order before submitting this form. Some orders require that you reach a minimum total amount of medical expenses before requesting reimbursement.

STATE OF MICHIGAN
JUDICIAL CIRCUIT
COUNTYREQUEST FOR HEALTH CARE
EXPENSE PAYMENT

CASE NO.

203 S Niles Street, Paw Paw, MI, 49079

(269) 657-7734

Plaintiff:

V

Defendant:

INSTRUCTIONS FOR REQUESTING PARTY:

The following is important information should you later seek to obtain the friend of the court's help to enforce payment of health-care

expenses (medical, dental, and other health-care expenses).

1. Your court order must require the other party to pay a portion of health-care expenses.
2. The expense must exceed any amounts your child support order requires as a prerequisite for enforcement.
3. You must submit your request for payment to the other party within 28 days of either the date the insurance provider has paid on the expenses or the date the insurance provider denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, and the agreement must list the expenses to be paid, state the total amount to be paid, and provide a schedule for payment. Both parties must sign the agreement.
5. The bills must be presented to the friend of the court on or before the following : one year after the expense was incurred, or six months after the insurer's final denial of coverage for the expense (as long as all measures necessary to submit the claim to insurance were completed within two months after the expense was incurred), or six months after a default in a repayment agreement as set forth above. You will need to fill out a second form to request enforcement.
6. In the event it is necessary for the friend of the court to enforce payment of the expenses, you must have supporting bills and receipts for the expenses you list. You will be responsible for establishing the expenses and their necessity. Please bring your documentation to all court hearings where medical expenses may be discussed.
7. Attach a copy of all bills and insurance notifications to this form.
8. **You must keep a copy of this form and all attachments for the friend of the court to use in the event enforcement action is necessary.**

Obligor's Name and Address

TO:

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: _____

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)