



ST. CLAIR COUNTY FRIEND OF THE COURT

31st Judicial Circuit
201 McMorran Blvd., Room 1600
Port Huron, Michigan 48060
Phone (810) 985-2285
www.stclaircounty.org/offices/foc

INSTRUCTIONS ON COMPLETING REQUEST FOR EXTRA ORDINARY MEDICAL REIMBURSEMENT

Enclosed are reimbursement forms to be used for uninsured health bills, including dental, vision and prescriptions.

- The **Total Cost** column must reflect the total cost for the child on the date of service.
- The **Insurance Payment** column should be the amount paid by any and all insurance for this date of service.
- **Uninsured Balance** is the difference between **Total Cost** and **Insurance Payment**, which is your out of pocket expense.
- Once you have completed the form, please submit it to the other party along with copies of all bills to allow him/her an opportunity to pay you directly for her/his percent of the uninsured amount, making sure to subtract the Ordinary Medical amount if appropriate. *
 - After 14 days, if payment is not received please submit a copy of what was sent to that party.
- Once reviewed, The Friend of the Court will send all to the other party. If there are no valid objections within 21 days, the amount will either be added to the account or, if the non-custodial parent is the one submitting the request, a child support credit may be given.

***Please note that it is not necessary for this information to be sent certified mail, as your signature and date on the form certifies that you sent the information to the other party.**



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Information Regarding Orthodontia

Each parent is *obligated* to comply with the Court Order. The Friend of Court recognizes orthodontia as a valid health care expense. The other party should be contacted *first* and made aware of the choice for orthodontia, the total cost, what the insurance will cover, what the payment plan will involve and any other pertinent information regarding the orthodontic bill. We cannot process any orthodontic bill that is past *one year* from the date of the *beginning* of the contract (the date the braces are placed on the minor child).

If the other party refuses to cooperate regarding the orthodontic bill, then a Friend of Court “Demand for Medical” form can be submitted to our office. In order for our office to be able to process any orthodontic bills we must have specific information. It is our policy that we must receive a detailed contract between yourself and the doctor’s office. The party requesting reimbursement must sign this contract and it must show that the party has committed to the payment plan. A contract is not the same as an estimate, which merely shows an expressed interest in orthodontia, rather it commits oneself to the plan. The contract must show what the entire procedure, start to finish including initial fees and monthly fees, will cost. The contract must also show what portion the insurance company will cover. If there is no insurance involved make sure that the doctor’s office includes that information on the contract. The orthodontist’s office needs to be made aware, that we will be contacting their billing department to verify all information given. We ask that you do not submit receipts on a monthly basis.

You must first send the completed forms to the other parent. After 14 days, if no payment you may submit the forms to the Friend of the Court office to request reimbursement assistance.

After we have received all of the requested information necessary to process a claim we will verify that the amounts listed on the Request for Extra Ordinary Medical Reimbursement forms are complete and accurate before sending your request to the other party for review. If no objections are received within 28 days our office will add that amount to the payer’s medical account. This will be charged onto the account based on the number of months indicated on the contract.

If you have any further questions, please feel free to contact this office. Thank you for your cooperation.