STATE OF MICHIGAN		COURT ORDER NO.
31ST JUDICIAL CIRCUIT ST CLAIR COUNTY	REQUEST FOR EXTRA ORDINARY MEDICAL REIMBURSEMENT	

ADDRESS: 201 MCMORRAN BLVD, ROOM 1600, PORT HURON, MI 48060 TELEPHONE NO: (810) 985-2285

Plaintiff:	Vs.	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. **If you are the Custodial Parent - The expense must exceed The Ordinary Medical Expenses of $345.00, $357.00, $403.00, $454.00, $200.00 (depending on the uninsured/ordinary medical language in your order) per child/per year as a prerequisite for enforcement.**

3. You must submit your request for payment to the other party within 28 days of either the date insurance has paid on the expenses or the date insurance denies payment.

4. The bills must be presented to the Friend of the Court within the earliest of: 1 year after the expense was incurred; 6 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 2 months after the expense was incurred); or 6 months after a default in a repayment agreement as set forth above.

5. 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.

6. You must keep a copy of this form for the Friend of the Court to use in the event enforcement action is necessary.

TO: Obligor's (*Person from whom you are seeking reimbursement*) name and address:

ATTACH COPIES OF ALL BILLS, WHICH MUST SHOW THE FOLLOWING INFORMATION:

- Patient's name
- Date of Service
- Cost of Service
- Type of Service

Year in which the medical bill(s) were incurred: 20_____

My current Annual Ordinary Medical amount is: $_____

Are you the Payer of Support or a Third Party Guardian? **Y / N**
(If Yes - you do not have to deduct the Ordinary Medical amount from the running total)
Was this amount already met with a previous submission for the same calendar year? **Y / N**
(If Yes - you do not have to deduct the Ordinary Medical amount from the running total)
Medical Percentage for each party: Plaintiff _____ Defendant_____

COURT ORDER NUMBER

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

DATE OF SERVICE	CHILD TREATED	PROVIDER/ INSTITUTION	NATURE OF TREATMENT	TOTAL COSTS	INSURANCE PAYMENT	UNINSURED BALANCE	RUNNING TOTAL

** If you have previously met the Ordinary Medical within the same calendar year, or if you are the Payer of support you do NOT have to subract the amount from the running total.

Once the total remaining cost is calculated you will subtract your percentage from that total. Example: if $223.00 remains and medical percentages are 35/65%. Multiply $223.00 x .35 (35%) = $78.05 or $223.00 x .65 (65%) = $144.95. **Subtract YOUR percentage from the total to get the obligor's balance owed

SUBTRACT ORDINARY MEDICAL	-
TOTAL	
Requesting party's %	-
Obligor Balance Owed	

COURT ORDER NUMBER

TOTAL OF REQUESTED EXTRA ORDINARY MEDICAL REIMBURSEMENT: $_____

I declare that the above statements are true to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expenses Payment to the obligor at his or her last known address.

DATE: _____ SIGNATURE: _____
CONTACT DAYTIME PHONE: _____

Requesting Party's Statement:

I request the Friend of the Court to enforce health care expenses. Attached to this form are all support documents in which copies have been given to the obligor. I declare that:

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.
2. This request is for expenses that are more than the minimum amount my order requires for enforcement.
3. This complaint is:
   *within 6 months after the date of the insurer's final denial of coverage for the expense.
   *within 1 year of the date the expense was incurred.
   *within 6 months after the obligor's default of an agreement to repay (copy of agreement attached).
4. As of this date, the expense information in the attached Request for Extra Ordinary Medical Reimbursement is true except as follows: Since the date I mailed the Extra Ordinary Medical Reimbursement to the obligor ***(Person from whom you are seeking reimbursement),*** the obligor **PAID** the amount of: $_____ for

_____ and _____
Name(s) of child(ren) Name(s) of medical provider(s)

I declare that the above statements are true to the best of my information, knowledge, and belief.

DATE: _____ SIGNATURE: _____

Submit this form to the Friend of the Court 14 days after sending to the other party, with copies of forms and all bills listed.

Notice to Obligor:

Under MCL 552.511a the Friend of the Court has been asked to enforce the health care expenses set forth below. Unless you file a written objection with the Friend of the Court within 28 days of the date provided in MCL 552.511a, the expenses will be added to your support account as a health care support arrearage and enforced. If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

_____ _____
Date Friend of the Court / Judicial Enforcement Analyst