

## MEDICAL REIMBURSEMENT FORMS

TUSCOLA COUNTY FRIEND OF THE COURT  
440 N. STATE STREET  
CARO MI 48723

### **Medical Explained:**

The Michigan Child Support Formula defines “**medical**” as treatments, services, equipment, medicines, preventative care, similar goods and services associated with oral, visual, psychological, medical and other related care, provided or proscribed by health care professionals for the child(ren).

**Routine medical care costs** for child(ren) do not qualify as medical expenses. (first-aid supplies, cough syrup and vitamins.)

**Ordinary medical expenses** include the support recipient’s (payee) co-payments, deductibles, and uninsured medical-related costs for all child(ren) in the case.

**Additional medical expenses** are the support recipient’s (payee) medical expenses for the child(ren) that exceed the child(ren)’s ordered annual ordinary medical expense amount, or the payer’s medical expenses for the child(ren). (The annual ordinary medical expense amount can be found on your Uniform Child Support Order in the Uninsured Health-Care expense section.)

### **INSTRUCTIONS TO REQUEST REIMBURSEMENT OF UNINSURED MEDICAL EXPENSES**

**Ordinary Medical Expense Tracking Sheet.** Receipts or copies of itemized statements for the expenses must be submitted. This tracking sheet will assist the payee in keeping track of their annual ordinary medical expense obligation. The annual obligation runs January-December and the amount is located on your order.

**Request for Health Care Expenses Payment (FOC 13).** (There are 2 pages to this form.) Read this form carefully and make certain that you are in compliance with the timelines that are required pursuant to MCL 552.511a. It is your responsibility to properly fill out this form and send it to the other party. The other party has 28 days to respond to your request. (The obligor is the person you are sending the form to for reimbursement. The obligor’s uninsured % will be on your order.)

**Complaint for Enforcement of Health Care Expense Payment (FOC 13a).** If the obligor has not made full payment within 28 days from the date you submitted your request to them, you may file this form with the Friend of the Court. Make sure to fill in the appropriate sections and attach all required documentation.

The Friend of the Court medical case worker is: Jamie Pierce, phone number 989-672-3215

**ORDINARY MEDICAL EXPENSE TRACKING SHEET**

<b>Date of Service</b>	<b>Child's Name</b>	<b>Amount of Service</b>

**Original receipts or copies of the itemized statements must be attached.**

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>REQUEST FOR HEALTH-CARE EXPENSE PAYMENT</b>	<b>CASE NO.</b>
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Friend of court address Telephone no.

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.**

TO:

Obligor's name and address
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Complete expenses incurred on the other side of this form.

Plaintiff

v

Defendant

CASE NO.

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

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due*	Obligor's %	Amt. Owed by Obligor

\*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.

Date

Signature

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT</b>	<b>CASE NO.</b>
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Court address Telephone no.

Plaintiff	<b>v</b>	Defendant
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**TO:** Obligor's name and address

**COMPLAINT**

I request the friend of the court to enforce health-care expenses. Attached is the request for health-care expense payment (including all supporting documents) 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 annual ordinary medical amount that can be collected as specified in the support order.
  - health-care expenses that have been incurred by the payer of support.
3. This complaint is
  - within six months after the date of the insurer's final denial of coverage for the expense.
  - within one year of the date the expense was incurred.
  - within six 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 health-care expense payment is true except as follows:  
 Since the date I mailed the request for health-care expense payment to the obligor, the obligor paid \$ \_\_\_\_\_  
 for \_\_\_\_\_ and \_\_\_\_\_.  
Name(s) of child(ren) Name(s) of medical provider(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**NOTICE**

The friend of the court has been asked to enforce health-care expenses. Unless you file a written objection with the friend of the court within 21 days of the date this notice is sent, the expenses will be added to your support account as a health-care support arrearage for enforcement and must be paid  in full by \_\_\_\_\_.  \$ \_\_\_\_\_ per month, except that the full balance will be subject to immediate enforcement.

If you timely file a written objection in the manner required, a hearing will be set to resolve the health-care complaint.

**CERTIFICATE OF MAILING**

I certify that on this date I served a copy of this complaint on the parties or their attorneys by first-class mail addressed to their last-known addresses as defined in MCR 3.203.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Friend of the court/Authorized representative