

# OAKLAND COUNTY FRIEND OF THE COURT

## FORMAL REQUEST FOR REIMBURSEMENT OF HEALTHCARE EXPENSES

As a support recipient, you may submit a formal Request for Healthcare Expenses that are **less than one year old** if the other party fails to respond to your informal request. If “ordinary medical expenses” are included in your order, total expenses **must exceed** the stated amount (\$289 or \$345 per child per calendar year) before you may submit a claim. Ordinary medical expenses include co-payments and deductibles, and most uninsured medical-related costs for all children in the case. Routine **remedial care costs** (e.g., first-aid supplies, cough syrup, and vitamins) **do not qualify** as medical expenses.

To submit a formal claim, please complete the following:

**AFFIDAVIT OF HEALTH CARE EXPENSES:** Complete the fields on the front and back of the form. This verifies that you paid total ordinary medical expenses in the amount of \$289 or \$345 per child per calendar year if required by your order.

**REQUEST FOR HEALTH CARE EXPENSE PAYMENT:** List all out-of-pocket expenses (exceeding the annual ordinary medical amount of \$289 or \$345 per child per calendar year if included in your order). As an example:

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
Josh	Dr. Fields	1/22/2005	Orthodontics	\$4000	\$1000	\$3000	50%	\$1500
Jenny	Dr. Baker	1/24/2005	Prescription	Co-Pay		\$10	50%	\$5

The “INSTRUCTIONS FOR REQUESTING PARTY” section of the form provides additional information.

**COMPLAINT:** Complete the required fields at the top of the Complaint For Enforcement Of Health Care Expense Payment form indicating the parties’ names and the obligor’s name. Complete the “Requesting Party’s Statement” provision by checking the box that applies to your situation under item No. 3, and the amount owed to you from the other party under item No. 4. Additionally, state the date of the Request for Health Care Expense Form and the amount owed. Do not forget your signature and date at the bottom of the form. Your Complaint form will be processed by the Friend of the Court and sent to the other party. If the other party does not reimburse you or does not file a written objection within 21 days after the mailing date, then the Friend of the Court will review the paid receipts and determine the amount of the other party’s obligation. An order will be entered to add the proven amount of health care costs to the arrearage of the Medical Reimbursement Account.

**OBJECTION HEARING:** A hearing will be scheduled **only** if the other party files a written objection within 21 days after the Complaint was mailed. If a hearing is set, you must bring all health care bills, receipts of payment, verification of any insurance payments, and any other pertinent proofs. Any frivolous objections may result in an order for costs to be paid to the requesting party, either directly or through the Friend of the Court. The Friend of the Court does not enforce payments that are to be made directly to the provider of health care services.

**SUBSEQUENT PAYMENT:** You must notify the Friend of the Court in writing if the other party pays you directly after the Complaint is mailed.

*EXPENSES SUBMITTED FOR ENFORCEMENT MUST BE LESS THAN ONE YEAR OLD*

*Additional forms are available at [www.oakgov.com/foc/index.html](http://www.oakgov.com/foc/index.html)*

<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 the Court address Telephone no.

Plaintiff	<b>v</b>	Defendant
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**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 insurance has paid on the expenses or the date insurance denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, 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 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. 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. Attached 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

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

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 Expense Payment to the obligor at his or her last known address.

\_\_\_\_\_  
 Date \_\_\_\_\_  
Signature