STATE OF MICHIGAN	**ORDERS WITH CHARGING MS ACCOUNTS**	COURT ORDER NO.
31ST JUDICICAL CIRCUIT ST CLAIR COUNTY	DOCUMENT OF ORDINARY MEDICAL EXPENSES	

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). ***** PAYMENTS ARE APPLIED TO ALL CHILD SUPPORT ARREARS (OWED TO STATE OF MI AND CUSTODIAL PARENT) BEFORE MEDICAL BILLS ARE REIMBURSED.*****

1. Effective October 1, 2004, your court order requires the recipient to document Ordinary Medical Expenses and submit this documentation when the amount specified in your order has been met. **The expense must exceed The Ordinary Medical Expenses of $289.00 or $345.00 (depending on your order), per child/per year as a prerequisite for enforcement.**
2. 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.
3. You must keep a copy of this form for the Friend of the Court to use in the event enforcement action is necessary.

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

A. Date of service
B. Patient's name
C. Type of service
D. Cost of service

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 BALANCE	UNINSURED BALANCE	RUNNING TOTAL UNINS. COSTS

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

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: _____ TOTAL UNINSURED: $_____

CONTACT DAYTIME PHONE: _____