Form #2

STATE OF MICHIGAN	**ORDERS WITH CHARGING MS ACCOUNTS**	COURT ORDER NO.
31ST JUDICIAL CIRCUIT ST CLAIR COUNTY	REQUEST FOR ADDITIONAL MEDICAL HEALTH CARE EXPENSE PAYMENT	

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. Your court order must require the other party to pay a portion of health care expenses.
2. **The expense must exceed The Ordinary Medical Expenses of $289.00, $345.00, $357.00 OR $403.00 (depending on your order) per child/per year as a prerequisite for enforcement.** Documentation of the Ordinary Medical must be included if not already in your file.
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, signed by both parties. List the expenses to be paid, state the total amount to be paid and provide a schedule of payment.
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. **If payment is not received from the other party within 14 days, you will need to fill out a Form #2 to request enforcement, and submit it along with this Form #1.**
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. 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:

A. Date of service **C. Type of Service**
B. Patient's name **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 PAYMENT	UNINSURED BALANCE	%	PAYER BALANCE **FOC use**

← IF YOU HAVE ADDITIONAL MEDICAL CLAIMS PLEASE USE REVERSE SIDE →

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 OWED: $_____

Form #2

STATE OF MICHIGAN	**ORDERS WITH CHARGING MS ACCOUNTS**	COURT ORDER NO.
31ST JUDICIAL CIRCUIT ST CLAIR COUNTY	REQUEST FOR ADDITIONAL MEDICAL HEALTH CARE EXPENSE PAYMENT	

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

Plaintiff: Vs. Defendant:

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

A. Date of service **C. Type of service**
B. Patient's name **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 PAYMENT	UNINSURED BALANCE	%	PAYER BALANCE **FOC use**

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 OWED: $_____

1-30-2018

STATE OF MICHIGAN	**FORM #3**	COURT ORDER NO.
31ST JUDICIAL CIRCUIT ST CLAIR COUNTY	COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSES	

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

Plaintiff:	Vs.	Defendant:

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

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 / Medical Enforcement Investigator

Requesting Party's Statement:

I request the Friend of the Court to enforce health care expenses. Attached is the request for Health Care Expense Payment, including all support 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 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 Health Care Expense Payment is true except as follows: Since the date I mailed the Request for Health Care Expense Payment 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.

1-30-2018