INSTRUCTIONS FOR HEALTH CARE EXPENSE PAYMENT

STEP ONE

Meet the annual ordinary medical amount listed in your child support order.

- If you are the ***PAYER*** of support, the annual ordinary medical amount is automatically met and you may **proceed to step two**.
- If you are the PAYEE, track your uninsured health-care expense using the Annual Ordinary Medical Expense Tracking Sheet until those expenses meet the total annual ordinary medical amount listed for all children on your child support order.
  - This amount must be met each year, starting on January 1.
  - Once the annual ordinary medical amount has been met, you may proceed to Step Two

STEP TWO

Submit the request for payment form to the other party.

- **Complete the Request for Health-Care expense Payment** form and the **Request for Health-Care Expense Payment Tracking Sheet** and send it to the other party **within 28 days** of either the date the insurance provider has paid on the expense or the date the insurance provider denies the expense.
  - Calculate the 28 days starting from the date of the first bill you receive from the medical provider, **as long as all available insurance has been applied to the bill.**
  - Attach a copy of the **explanation of benefits statement (if available)** and a **copy of the bill** from the medical provider to the Request for Health-Care Expense form before you send it to the other party.
  - If the other party **does not pay their portion** of the uninsured medical expense **to you within 28 days** of the date you request payment, **proceed to Step Three.**

STEP THREE

Request enforcement from Friend of the Court (FOC)

- **Complete the Complaint and Notice for Health-Care Expense Payment** form up to the section titled "Notice" and submit it to your FOC office. (FOC will complete the rest of the form)
  - Attach the following to your complaint:
    - **Annual Ordinary Medical Expense Tracking Sheet (with all attachments).**
    - Each **Request for Health-Care Expense (with all attachments)** you submitted to the other party.
  - **Do Not** submit the complaint until you have **at least $100.00 worth of medical expenses** for which to request enforcement.
  - Submit the Complaint to the FOC **within one year after the expense was incurred** (meaning the date of service, which can be found on the bill from the medical provider) or **within six months after the date of the insurer's final denial of coverage for the expense.**

INSTRUCTIONS FOR COMPLETING
ANNUAL ORDINARY MEDICAL EXPENSE TRACKING SHEET

Ⓐ Enter the name of the plaintiff on your case.

Ⓑ Enter the name of the defendant on your case.

Ⓒ Enter the case number of your case.

Ⓓ Enter the Annual Ordinary Medical Expense (OME) amount.

- This amount can be found in the Uninsured Health-Care Expense box on your child support order.
- You must use the total for all of the children active on the case.
- If your order started part way through the year, was modified part way through the year, or if a child emancipated at some point during the year for which you are calculating the OME, you should contact the Friend of the Court office to ask what number you should use.

Ⓔ Instructions for the expense chart.

- Enter the name of the child receiving service.
- Enter the name of the medical provider (e.g., doctor's name, dentist's name, etc.)
- Enter the date of the service, which can be found on the bill from your medical provider.
- Enter the type of service (e.g., what type of service, reason for service, etc.)
- Enter the total cost of the service from the bill from the medical provider, minus any adjustments or discounts listed on the bill.
- Enter the amount paid by insurance, which can be found on the bill from the medical provider.
- Enter the balance due, which can be found on the bill from the medical provider.
- Enter the date that you paid the bill.
- Enter the amount you paid.

Continue to enter the information for each bill you have beginning January 1st of each year until the total calculated in Ⓕ, below, equals the OME found in Ⓓ, above.

Ⓕ Enter the total paid in this column.

- Once the total equals your OME amount, you can move on to Step Two on the Instructions for Health Care Expense Payment.

Ⓖ Additional Instructions

For each entry on the Annual Ordinary Medical Expense Tracking Sheet, attach a copy of the bill and the proof of payment (e.g., canceled check, medical provider receipt, etc.) showing you paid the bill. All bills and proofs of payment must show the name of the child who received the service.

Hold on to the Annual Ordinary Medical Expense Tracking Sheet and all its attachments in case you need to submit them to the FOC office in Step Three on the Instructions for Health Care Expense Payment.

ANNUAL ORDINARY MEDICAL EXPENSE TRACKING SHEET

Plaintiff	v	Defendant	CASE NO.

The current Ordinary Medical Expense (OME) listed in my order is $_____.

Name of Child Receiving Services	Name of Medical Provider	Date of Service	Type of Service	Total Cost of Service	Amt. Paid by Insurance	Balance Due*	Date Paid	Amount Paid
							Total Paid (must at *least* meet the total of the OMS listed at the top of this page)	

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

_____
Date

_____
Signature

INSTRUCTIONS FOR COMPLETING REQUESTS FOR HEALTH-CARE EXPENSE PAYMENT TRACKING SHEET

Ⓐ **Enter the name of the plaintiff on your case.**

Ⓑ **Enter the name of the defendant on your case.**

Ⓒ **Enter the case number of your case.**

Ⓓ **Complete the expense chart.**

- Enter the name of the child receiving service.
- Enter the name of the medical provider (e.g., doctor's name, dentist's name, etc.)
- Enter the date of the service, which can be found on the bill from your medical provider.
- Enter the type of service (e.g., what type of service, reason for service, etc.)
- Enter the total cost of the service from the bill from the medical provider, minus any adjustments or discounts listed on the bill.
- Enter the amount paid by insurance which can be found on the bill from the medical provider.
- Enter the balance due, which can be found on the bill from the medical provider.
- Enter the obligor's %, which can be found in the Uninsured Health-Care Expenses box on your child support order.
- Enter the Amount Owed by Obligor, which can be calculated by multiplying the Balance Due by the Obligor's %.

Ⓔ **Enter the Total Owed by adding each amount owed by the obligor from this column.**

Ⓕ **Additional Important Instructions.**

For each entry on the Request for Health-Care Expense Payment Tracking Sheet, attach a copy of the bill from the medical provider and corresponding explanation of benefits from your insurance company (if available) to the form.

Hold on to a copy of the Request for Health-Care Expense Payment Tracking Sheet and all its attachments in case you need to submit them to the Friend of the Court office in Step Three of the Instructions for Health-Care Expense Payment.

REMINDER: You must submit the Request for Health-Care Expense Payment form and the Request for Health-Care Expense Payment Tracking Sheet (with all the necessary attachments) to the other party **within 28 days of either the date the insurance provider has paid on the expense or the date the insurance provider denies the expense.**

⊕ Calculate the 28 days starting from the date of the bill from the medical provider.

REQUEST FOR HEALTH-CARE EXPENSE PAYMENT TRACKING SHEET

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

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

Date

Signature

INSTRUCTIONS FOR COMPLETING.
REQUEST FOR HEALTH-CARE EXPENSE PAYMENT FORM

Ⓐ **Enter the number of your case.**

Ⓑ **Enter the name of the plaintiff on your case.**

Ⓒ **Enter the name of the defendant on your case.**

Ⓓ **Enter the name and address of the obligor**

- On this form, the obligor is the other party on your case, or the individual who should pay to you their portions of the health-care expense.

REMINDER: You must submit the Request for Health-Care Expense Payment form and the Request for Health-Care Payment Tracking Sheet (with all of the necessary attachments) to the other party **within 28 days of either the date the insurance provider has paid on the expense or the date the insurance provider denies the expense.**

⊖ Calculate the 28 days starting from the date of the bill from the medical provider.

Approved, SCAO

Original - Obligor
1st copy - Requesting party
2nd copy - For court as needed

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

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

Complete expenses incurred on the other side of this form.

INSTRUCTIONS FOR COMPLETING
COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT

Ⓐ Enter the case number and name of the judge on your case.

Ⓑ Enter the name of the plaintiff on your case.

Ⓒ Enter the name of the defendant on your case.

Ⓓ Ener the name and address of the obligor.

- On this form, the obligor is the other party on your case, or the individual who should pay to you their portion of the health-care expense.

Ⓔ Complete the Complaint section of the form.

- Mark the appropriate box under numbers 2 and 3, fill in the blanks in number 4 (if applicable), and date and sign the complaint.
- The FOC office will complete the NOTICE and CERTIFICATE OF MAILING sections.

Ⓕ Attach Required Documents.

- Attach a copy of the completed Annual Ordinary Medical Expense Tracking Sheet (with all attachments)
- Attach a copy of each completed Request for Health=Care Expense Payment and the Request for Health-Care Expense Payment Tracking Sheet (with all attachments) that was sent to the other party for which you are fining the complaint.

  ⊖ If you have more than one Request for Health-Cre Expense Payment form and Tracing Sheet, you may attach them all to one Complaint and Notice for Health-Care Expense Payment.

Ⓖ Submit the Complaint and Notice for Health-Care Expense Payment (and the documents required to the attached in step Ⓕ) to the Friend of the Court Office.

REMINDER: Do not submit the Complaint and Notice for Health-Care Expense Payment to the FOC Office until you have at least $100 in medical expense for which you are requesting enforcement.

REMINDER: You must submit the Complaint and Notice for Health-Care Expense Payment to the FOC Office within one (1) Year of the date the expense was incurred or within six (6) months after the date of the insurer's final denial of coverage for the expense.

⊖ Calculate the date the expense was incurred as one (1) year from the *date of service* listed on your explanation of benefits or bill from the medical provider.

⊖ Calculate the date of the insurer's final denial of coverage as six (6) months after you receive the bill from the medical provider that reflects that the insurance was denied.

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO. and JUDGE

Court address

Court telephone no.

Plaintiff's name

v

Defendant's name

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 served a copy of this complaint on the parties or their attorneys by first-class mail addressed to their last-known addresses as defined by MCR 3.203. I declare under the penalties of perjury that this certificate of mailing has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____ _____
Date Friend of the court/Authorized representative

Distribute form to:
Friend of the court
Obligor
Requesting party