

Approved, SCAO

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

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| STATE OF MICHIGAN 34th JUDICIAL CIRCUIT Roscommon COUNTY | REQUEST FOR HEALTH-CARE EXPENSE PAYMENT | CASE NO. |
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Friend of court address Telephone no.
 500 Lake Street, Roscommon, MI 48653 (989) 275-1902

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.

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| Plaintiff | v | Defendant | CASE NO. |
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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 |
|---------------------------------|--------------------------|-----------------|-----------------|--------------------|------------------------|--------------|-------------|----------------------|
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*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.

_____ Date
 _____ Signature

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STATE OF MICHIGAN
34th JUDICIAL CIRCUIT
Roscommon COUNTY

COMPLAINT AND NOTICE FOR
HEALTH-CARE EXPENSE PAYMENT

CASE NO.

Court address

500 Lake Street, Roscommon, MI 48653

Telephone no.

(989) 275-1902

Plaintiff

v

Defendant

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:

- I requested payment within 28 days of the date notified of the balance due after insurance payments.
- 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.
- 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).
- 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