

DEMAND FOR MEDICAL PAYMENT INSTRUCTIONS

You have requested the assistance of the Montcalm County Friend of the Court for enforcement of medical bills. This office will assist you if the court order provides for the payment of medical bills and the bills are **less than one year old**. **DO NOT** submit any bills to our office until all available insurance benefits have been paid and you have unsuccessfully attempted to collect from the other parent.

1. **BEFORE** completing the attached form, you must submit a copy and explanation of the medical bills to the other party and give them thirty (30) days to make payment or payment arrangements with you. **Also, if your child support order includes a portion for ordinary medical, you will have to meet the annual ordinary medical amount prior to completing this form.** Only list those bills on the form that remain outstanding **after the annual ordinary medical amount the payee must pay each year is met.*** Please include a note along with your form that the bills are above and beyond the ordinary medical otherwise the form may be returned to you for clarification.

* The Michigan Child Support Formula requires the non-custodial parent to pay an additional sum each month as medical support that is part of the total child support amount. The custodial parent is, therefore, required to pay \$345.00 per child annually (2 m/children=\$690.00, 3 m/children=\$1,035.00...) before submitting the Demand for Medical request to the Montcalm County Friend of the Court.

2. **After the thirty (30) days have expired**, complete the following form. Further, the following information **MUST** be included on the form:

- a. Your case / court number
- b. Plaintiff and Defendant
- c. Payer's name and address (the other parent whom you are seeking payment from)
- d. Name of child receiving service
- e. Name of medical provider/facility providing treatment
- f. The date of service
- g. The type of service / treatment
- h. The total medical cost
- i. The amount that was paid by insurance, including any special deductions /credits
- j. The amount that the custodian paid (amount you paid that is over and above the annual ordinary medical amount)
- k. The balance that is still owed to the PHYSICIAN/PROVIDER. This is not the amount owed to you, rather the amount that is still owed to the medical provider.
- l. Date and sign the form
- m. **DO NOT** write below the line where you sign your name
- n. **DO NOT** use pencil or colored ink. Use black or blue pen only

Return the **ORIGINAL** to our office. You will then receive a copy of this form from our office with the payer's amount due completed.

3. Wait thirty-five (35) days from the date of the mailing by the Court, and if the payer has not contacted you to make payment or payment arrangements, you must send written notice to our office that you wish additional action be taken. If a court hearing is scheduled to address the medical bills, **you must appear and bring copies of the medical bills with you.** If you fail to appear for the court hearing, the court may dismiss your Demand for Medical form. NOTE: If the hearing is dismissed, these bills **cannot** be resubmitted to our office for future demands.

******* I declare that I have informed and provided copies of the medical bills and receipts to the other parent on:**

Date: _____ Recipient's Signature: _____

STATE OF MICHIGAN 8TH JUDICIAL CIRCUIT MONTCALM COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.
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Friend of court address Telephone no.
 629 N STATE ST, PO BOX 305, STANTON, MI 48888 (989) 831-7332

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.

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

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

TOTAL MEDICAL COSTS \$ _____

X _____ %

TOTAL DUE FROM PAYER \$ _____

DATE OF MAILING _____

BY _____
FRIEND OF THE COURT OFFICE