STATE OF MICHIGAN

DERRICK MORRIS
FRIEND OF THE COURT

P.T. BUCK FOLTZ
MEDIATOR

DREW BASTMAN
ASST. FRIEND OF THE COURT

JACKSON THIBAULT
ENFORCEMENT OFFICER

FRIEND OF THE COURT

BARAGA, HOUGHTON & KEWEENAW COUNTY
401 EAST HOUGHTON AVENUE - HOUGHTON, MI 49931
PHONE: (906) 482-2102 – FAX: (906) 482-9552

INSTRUCTIONS FOR SUBMITTING DEMAND FOR MEDICAL FORMS TO THE HOUGHTON, BARAGA and KEWEENAW COUNTY FRIEND OF THE COURT

1. Before you attempt to use this collection mechanism, you must ***first*** request payment from the non-custodial parent. Only upon the non-custodial parent's refusal to make payment can this form be used.
2. If you have made payment for the medical expenses, we ask that you provide us with proper verification, receipts, etc.
3. You **MUST** submit proof of that portion paid by any/all insurances. If insurance coverage was denied, you must submit proof of denial.
4. You must attach to the Demand for Medical form, an itemized supporting bill for each expense listed, that specifies the minor child it pertains to. Statements that indicate "previous balance" or "carried forward" will not be accepted.
5. Do not report the same charge on subsequent Demand for Medical forms.
6. We can only help with the reimbursement of current bills**. NO DEMAND FOR MEDICAL PAYMENT WILL BE PROCESSED FOR CARE THAT WAS INCURRED MORE THAN ONE (1) YEAR PRIOR TO THE DATE THE DEMAND FORM IS SUBMITTED TO THE FRIEND OF THE COURT OFFICE.**
7. The ordinary medical amount that the custodial parent is responsible for must be deducted from the amount requested each year. This amount can be found on the parties' most recent Uniform Child Support Order, along with percentages for each parties' out-of-pocket responsibility.
8. This form will be returned to you if not completed correctly.

I HAVE MET ALL OF THE ABOVE REQUIREMENTS:

PETITIONERS SIGNATURE: _____ DATE: _____

Please see that this Demand Form is returned to the Friend of the Court office. Thank you!

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.

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 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
							0.00%	
							0.00%	
							0.00%	
							0.00%	
							0.00%	

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

Date

Signature