Approved, SCAO

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

STATE OF MICHIGAN 28th JUDICIAL CIRCUIT Wexford/Missaukee 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

Wexford/Missaukee County Friend of the Court
Instructions for requesting reimbursement for Uninsured Medical Expenses

Please Note:

Payee: If you are the receiver of support on the case you must have paid the annual ordinary medical amount before you are eligible to request reimbursement for uninsured medical expenses plus you must provide proof of payment.

Payor: If you are the payer of support on the case and have paid medical bills, you may submit them immediately to the payee. Your portion of the annual ordinary medical amount is paid through your monthly support obligation.

1. Review your current Uniform Support Order to see if it requires the other party to pay a percentage of uninsured medical cost. This can be found following the support obligation in the paragraph titled "Uninsured Health-Care Expenses".

2. To start the reimbursement process, **You must submit your request to the other party within 28 days of either the date insurance has paid toward the expenses or the date insurance denies payment**.

3. To submit the request to the other party **you must complete FOC 13** and include a copy of the billing statement and all copies of receipts. (See example below on how to complete the FOC 13)

Example:

Name of child Receiving Service	Name of Med Provider	Date of Service	Type of Service	Total Med Cost	Amt. Pd by Insur	Bal Due	Obligor's %	Amt Owed by Obligor
Joey Smith	Dr. Brooks	1/12/17	Dental	125.00	75.00	50.00	50%	25.00

4. Complete the FOC 13 with the required attached documents, sign, and date it. The date should reflect the date you mailed or provided form and documents in person to the other party. The other party will have 28 days to respond. They may 1) pay their portion to you, 2) agree **IN WRITING** to a payment plan with you, both parties must sign this agreement or 3) disagree with the bill and make no payment.

5. If you are unable to come to an agreement or have not received payment following the 28th day, then you may request enforcement of the other party's unpaid portion. To do so simply provide the Friend of the Court Office a copy of the FOC 13 with all attachments and proof of payment of the Annual Ordinary Medical unless you are the payer. The Friend of the Court shall then review all the paperwork to insure that it complies with your court order for reimbursement. The request of enforcement must be filed with the Friend of the Court Office within 1 year after the expense was incurred. **The Friend of the Court will only enforce reimbursements for bills that you have paid. If you are making payments on a medical bill, the Friend of the Court will enforce the other parties' percentage of the payments you have made.**

6. Following a review of your paperwork you will receive a complaint form with instructions in the mail. Simply complete the form and return it. The Friend of the Court will notify the other party in the case of the enforcement action. It is possible that an objection hearing may occur if the other party disagrees with reimbursement. ***It is your responsibility to provide the court with proof that you have reached and exceeded your Ordinary Medical Amount for the year. The Ordinary Medical Amount renews at the start of each calendar year***

The Friend of the Court recommends that when a payment is made between the parties, it be in the form of a check or money order so there is record of the payment. If you have any questions on this process please feel free to contact the Medical Enforcement Caseworker

***Keep all copies of your bills, receipts and request for your records.**

****ORTHODONTIA – see attached policy.**

ORTHODONTIA POLICY for
Wexford Missaukee Friend of the Court

Request for orthodontia reimbursement through FOC:

It is important to note the following when you are seeking reimbursement from the other parent for orthodontia expenses for your child(ren):

- A copy of the original signed contract must be included with the medical reimbursement form.
- You must also include proof of the down payment, if required, was made (i.e.: cancelled check, credit card receipt, etc.).
- Braces must be on the teeth.
- You must have met the Annual Ordinary Medical Expense for the year and show proof of payment.
- You must complete and send form "Request for Health Care Expense Payment" along with the orthodontic contract and proof of payment to the other parent and wait 28 days before submitting a copy of the "Request for Health Care Expense Payment", with all attachments listed above, to FOC medical worker to begin the reimbursement process.
- To avoid delays in processing, make sure request is at least 28 days after the date you provided it to the other parent.
- Once FOC medical worker reviews and determines you qualify for reimbursement you will be mailed a "Complaint for Health Care Expense Payment" that must be completed and returned to FOC medical worker.
- FOC medical worker will then mail the Complaint to the other parent for payment.
- Orthodontia is a 1 (one) time expense request, meaning the total cost of the braces (minus the yearly OME) will be calculated at the percentages listed on your most recent Uniform Child Support Order and will be billed to the paying party at $50.00 monthly.