STATE OF MICHIGAN 27TH JUDICIAL CIRCUIT NEWAYGO COUNTY Family Division	REQUEST FOR ENFORCEMENT OF MEDICAL EXPENSES	**DOCKET NO:** **IV-D NO:**

Friend of the Court Office, 1092 Newell Street, P.O. Box 885, White Cloud, MI 49349 FAX (231) 689-7015 (231) 689-7260

Requesting party's statement:

1. I request the Friend of the Court to enforce medical expenses.

One of the following must be checked

2. ☐ This request is for medical expenses that were incurred above the ordinary medical established for my docket and I have attached a copy of the Ordinary Medical Expense Log.

For example, if your order states that you must incur uninsured medical expenses of $289.00 per child per year, then prior to submitting the Request for Enforcement of Medical Expenses to the FOC for processing, you must insure that the total threshold amount, determined by the number of children on your case, has been met.

☐ This request is for medical expenses that were incurred. There is no ordinary medical account at FOC.

One of the following must be checked

3. ☐ I requested payment from the other party after insurance paid their share and have allowed 28 days for payment to be made to the provider or me.

If Ordinary Medical provisions are part of your order, the amt requested is above the established threshold.

☐ I requested payment from the other party within 28 days after the expense/expenses were incurred, as there is no medical insurance.

If Ordinary Medical provisions are part of your order, the amt requested is above the established threshold.

One of the following must be checked

4. ☐ This request is within 6 months after the date of the insurance final coverage of the expense.

☐ This request is within 1 year of the date the expense was incurred.

I declare that the above statements are true to the best of my information, knowledge and belief.

____________________________ ____________________
Signature Date

Notice to party receiving this request:

Under MCL 552.511a, the Friend of the Court has been asked to enforce the medical expenses described on the attached page. Unless you file a written objection with the Friend of the Court within 21 days of the "Date of Mailing by FOC" the expenses will be added as a medical account arrearage and enforced.

If you file a written objection, a Court hearing will be set by FOC to resolve the medical expense request.

If you file a written objection, you must sign below and attach a copy of this page with your written objection.

____________________________ ____________________
Signature Date

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Plaintiff:	V	Defendant:

You have requested the assistance of the Friend of the Court in the enforcement of medical, hospital, optical and/or dental bills. If your court order provides for the payment of uninsured medical expenses, this office will assist you if you have completed the requirements on Page 1.

Date FOC received ➡

Complete this form (front and back) in full.

Attach copies of itemized bills / statements for the medical expenses you list and the Ordinary Medical Expense Log if applicable. The name of health care provider, the name of the patient, date of service and nature of service provided must be printed on the itemized bills / statement.

Submit one (1) copy of the Request for Enforcement of Medical Expenses for all expenses claimed below.
Submit three (3) copies of all itemized bills / statements for all expenses claimed below.
Submit one (1) copy of the Ordinary Medical Expense Log (if you have an Ordinary Medical account at FOC).

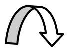
If applicable, the Request for Enforcement will be added as owing on a medical reimbursement (MR) account & collected by FOC.

Name of Child	Physician or Institution	Date of Service	Nature of Service	Total Cost	Amt Ins Paid	Balance Due

I declare that the above statements of past due medical, hospital, optical and/or dental bills for the minor child (ren) are the true amounts not covered by any insurance, to the best of my information, knowledge and belief.

_____________________________ Signature

_______________ Date

 **DO NOT WRITE BELOW - FRIEND OF THE COURT USE ONLY**

____ The Request for Enforcement is being returned, as supporting documentation required has not been properly submitted.

____ The Request for Enforcement is being returned, as Ordinary Medical Expenses paid by the CP towards the total amount of $ __________ have not been met.

____ Request for Enforcement pmts have been processed per Court Order eff __________ PL _____ % DF _____ %

Balance of extraordinary medical not paid by insurance: $ __________

Percentage to be paid by obligated party: x _____ %

____ The total amount due by obligated party in the amount of $ __________ **will be added to your account on the 22nd day after the "Date of Mailing by FOC" below.**

_____________________________ Signature

_______________ Date of Mailing by FOC