INSTRUCTIONS FOR FILING THE COMPLAINT AND REQUEST FOR HEALTH CARE EXPENSE PAYMENT FORMS

The Friend of the Court (FOC) can assist you with bills with a date of service that has occurred less than one year ago. If the date of service was over one year ago, FOC can only process the expense with proof that the insurance company paid or denied the claim within the last six months.

The requesting parent will be responsible for payment to the service provider. The FOC will enforce the other parent's share of the expenses if the following process is followed:

1. You must request payment from the other parent **within 28 days** after the receipt of the final insurance payment or denial from the insurance company.

2. Complete the **Request for Health Care Expense Payment** form and send it to the other parent*. Be sure to write the docket number and the name of the Plaintiff and Defendant in the appropriate spaces provided. Each expense must be entered on page two and itemized. In addition, you must provide copies of the bills and proof of insurance payment. The bills provided to the other parent should include the following information:

    - The name of the child receiving the service
    - The name of the provider
    - The date of service
    - Type of Service provided
    - The total cost of the service including all adjustments, discounts, insurance payments, and final out of pocket amount
    - If your statement doesn't provide this information, an Explanation of Benefits (EOB) from the insurance providers showing what was paid or rejected and/or a copy of the complete billing statement showing what was paid and who paid (parent or insurance provider) is sufficient
    - If submitting orthodontia, a copy of signed orthodontic contract and proof of down payment, if applicable

    It is best to make a copy of all the information provided to the other parent including the Request for Health Care Expense Payment form for future reference.

*Please note that it is not necessary for this information to be sent certified mail, as your signature and date on the form certifies that you sent the information to the other parent.

INSTRUCTIONS (Continued)

3. Allow the other parent **28 days** to pay you directly.

4. If you have not received payment from the other parent after 28 days, you may file the **Complaint for Enforcement of Health Care Expense Payment** form with the FOC. To complete the Complaint for Enforcement of Health Care Expense payment form, you must fill in the docket number and Plaintiff and Defendant names. You must also complete the Requesting Party's Statement, checking each box to ensure eligibility for processing. Do not forget to sign and date the form or it will be returned to you.

5. Include a copy of the original Request for Health Care Expense Payment form and the bills and/or EOB's that you provided to the other parent. The completed Request for Health Care Expense Payment form, Complaint for Enforcement of Health Care Expense Payment form, and all supporting documentation should be mailed to Kent County Friend of the Court, 82 Ionia Ave NW, PO Box 351, Grand Rapids, MI 49501-0351. You may choose to fax to 616-632-6876 or email to FOC.Mail@kentcountymi.gov

Once the forms and supporting documentation are received by the FOC, the request will be processed and a copy will be sent to each parent showing what is owed. The FOC will hold on to all the documents for 21 days to allow the receiving parent the opportunity to object. If an objection is received within the allotted time period, a motion will be filed with the Circuit Court and an objection hearing will be scheduled. If no objection is received within 21 days, the expenses will be added to the account and the FOC will begin collection or credit the account.

If you have any further questions, please feel free to contact the Health Care Enforcement Unit at 877-543-2660.

STATE OF MICHIGAN 17th JUDICIAL CIRCUIT KENT COUNTY	COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSE PAYMENT	DOCKET NUMBER:

Friend of the Court address:
82 Ionia, NW, 2nd Floor, P.O. Box 351, Grand Rapids, MI 49501-0351

Telephone number:
(877) 543-2660

PLAINTIFF	V	DEFENDANT

Requesting party's statement:

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 other party. **I declare that :**

1. (___) I requested payment from the other party within 28 days of the date notified of the balance due after insurance payments.

2. (___) I am the custodial parent and this request is for expenses that are more than the annual ordinary medical amount my order requires for enforcement.

Or

(___) My order does not contain an ordinary medical threshold requirement or I am the payer of support.

3. (___) This complaint is (check one of the following):
   (___) within 6 months after the date of the insurer's final denial of coverage for the expense.
   (___) within 1 year of the date the expense was incurred.

As of this date, the expense information in the attached Request for Health Care Expense Payment is true except as follows:

On this date _____, I mailed the Request for Health Care Payment with supporting documentation to the other party, and he/she has paid $_____ toward said expenses.

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

_____ _____

Date Signature

Notice to party receiving this complaint:

Under MCL 552.511a, the Friend of the Court has been asked to enforce the health care expense described on the attached page(s). Unless you file a written objection with the Friend of the Court within 21 days of the date provided in MCL 552.511a, the expenses will be added to your support account as a health care support arrearage and enforced. If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the other party by ordinary mail to his/her last known address.

_____ _____

Date Friend of the Court/Authorized Representative

STATE OF MICHIGAN 17th JUDICIAL CIRCUIT KENT COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	DOCKET NUMBER:

Friend of the Court address:
82 Ionia, NW, 2nd Floor, P.O. Box 351, Grand Rapids, MI 49501-0351

Telephone number:
(877) 543-2660

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 insurance has paid on the expenses or the date insurance denies payment. You must then allow the other party 28 days to remit payment to you. If the other party does not remit payment within 28 days, you can request enforcement from the Friend of the Court.

4. The bills must be presented to the Friend of the Court on or before the following: 1 year after the expense was incurred or 6 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 2 months after the expense was incurred). You will need to fill out a second form to request enforcement.

5. 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.

6. Attach a copy of all bills and insurance notifications to this form.

7. 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.

***** Complete expenses incurred on page 2 of this form.*****
*****Please make any notations for the receiving party under #3, below.*****

TO:

Receiving party's name and address

INSTRUCTIONS TO RECEIVING PARTY:

1. You are being asked to pay your court ordered share of uninsured health care expenses, as detailed on the attached page. At this point, payment(s) should be made directly to the other parent.

2. If after 28 days you have failed to make payment, the requesting party has the option of submitting these bills to the Friend of the Court Office for collection from you.

3. Note from requesting party (if any):

STATE OF MICHIGAN 17th JUDICIAL CIRCUIT KENT COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	DOCKET NUMBER:

Friend of the Court address:
82 Ionia, NW, 2nd Floor, P.O. Box 351, Grand Rapids, MI 49501-0351

Telephone number:
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PLAINTIFF	V	DEFENDANT

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

CHILD'S NAME	PHYSICIAN/ INSTITUTION	DATE OF SERVICE	NATURE OF SERVICE	TOTAL HEALTH CARE COST	AMOUNT PAID BY INSURANCE	TOTAL UNINSURED AMOUNT

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 other party at his or her last known address.

Date: _____ Signature: _____

Printed Name: _____