27TH JUDICIAL CIRCUIT COURT OF MICHIGAN
FAMILY DIVISION

Oceana County

Anthony A. Monton
Circuit Judge

Bradley G. Lambrix
Family Court Judge

Friend of the Court

Oceana Co. (231) 873-4605
Fax (231) 873-0252

OCEANA COUNTY FRIEND OF THE COURT

Courthouse M-10, 100 State Street
Hart, Michigan 49420

Dear Party:

Each parent is responsible for uninsured medical expenses based on the percentages outlined in your court order. Uninsured medical expenses are any expenses that insurance does not cover, for example, co-pays, deductibles, prescriptions, and other non-covered medical expenses. The following is information on the Friend of the Court's policies and procedures on how the Payee (party who is submitting uninsured medical bills) is responsible for submitting the expenses to the Friend of the Court and to the Obligor (party who is receiving the uninsured medical bills).

To request payment, you must first submit copies of bills and receipts to the obligated parent. The obligated parent must be allowed **28 days** after you've noticed him/her to respond to you by either making payment in full or payment arrangements. If the obligated parent fails to do either, then complete the Request for Health Care Expense Payment form and submit this information to the Friend of the Court. Verification of submission of the bills to the obligated parent will be required when the Request for Health Care Expense Payment form is submitted.

You as the Payee must submit supporting documents (billing and receipts) that clearly show the name of the health care provider printed on the billing/receipt. The bills/receipts must also indicate the patient's name, the date of service, and the nature of the service provided. Please be aware that you must submit uninsured medical expenses to the Friend of the Court **within 1 year** that the expense is incurred.

To ensure that there is no money paid to the Payee or the provider, you must complete the area referred to as the Requesting Party's Statement on the Complaint for Enforcement of Health Care Expenses form. By completing this form you are swearing to the court that the obligated parent did not make any payment to you or the medical provider.

Once the forms are complete, you may send the forms with the supporting documents to the Friend of the Court for further processing. A determination of your claim will be made and enforcement will begin. The obligated parent will have **21 days** to make payment to you or to the medical provider. If the obligated parent fails to make payment or payment arrangements please notify the Friend of the Court in writing so that a medical arrears account can be established. The Obligor will then have to make payment the medical arrears account through our office.

If you need assistance or have any other questions on how to complete this form please contact our office.

Sincerely,

Amanda Riddle

Amanda Riddle
Oceana County Friend of the Court
Medical Enforcement Caseworker

Approved, SCAO

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

STATE OF MICHIGAN 27th JUDICIAL CIRCUIT Oceana COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Friend of court address
100 State St. Ste. M-10 Hart, MI 49420

Telephone no.
(231) 873-4605

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

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

Date

Signature

Approved, SCAO

Original - Friend of the court
1st copy - Obligor
2nd copy - Requesting party

STATE OF MICHIGAN 27th JUDICIAL CIRCUIT Oceana COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Court address: 100 State St. Ste M-10 Hart, MI 49420

Telephone no.: (231) 873-4605

Plaintiff

v

Defendant

TO: Obligor's name and address

COMPLAINT

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 obligor. **I declare that:**

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.
2. This request is for
   - ☐ expenses that are more than the annual ordinary medical amount that can be collected as specified in the support order.
   - ☐ health-care expenses that have been incurred by the payer of support.
3. This complaint is
   - ☐ within six months after the date of the insurer's final denial of coverage for the expense.
   - ☐ within one year of the date the expense was incurred.
   - ☐ within six months after the obligor's default of an agreement to repay (copy of agreement attached).
4. As of this date, the expense information in the attached request for health-care expense payment is true except as follows: Since the date I mailed the request for health-care expense payment to the obligor, the obligor paid $ _____ for _____ (Name(s) of child(ren)) and _____ (Name(s) of medical provider(s)).

Date

Signature

NOTICE

The friend of the court has been asked to enforce health-care expenses. Unless you file a written objection with the friend of the court within 21 days of the date this notice is sent, the expenses will be added to your support account as a health-care support arrearage for enforcement and must be paid ☐ in full by _____. ☐ $ _____ per month, except that the full balance will be subject to immediate enforcement.

If you timely file a written objection in the manner required, a hearing will be set to resolve the health-care complaint.

CERTIFICATE OF MAILING

I certify that on this date I served a copy of this complaint on the parties or their attorneys by first-class mail addressed to their last-known addresses as defined in MCR 3.203.

Date

Friend of the court/Authorized representative