

27<sup>TH</sup> JUDICIAL CIRCUIT COURT OF MICHIGAN  
FAMILY DIVISION

Oceana County

Terrence R. Thomas  
Anthony A. Monton

Circuit Judges



OCEANA COUNTY FRIEND OF THE COURT

Bradley G. Lambrix  
Family Court Judge

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

Friend of the Court

Oceana Co. 231/873-4605  
Fax 231/873-0252

Dear Party:

As you may be aware of 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 etc. 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 expenses).

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

You as the Payee, must submit supporting documents (billing and receipts) pertaining to the Request for Health Care Expense Payment. The name of the health care provider must be printed on the bill or receipt. Also, each bill or receipt must indicate the name of the patient, date of service and the nature of the service provided. Please note that you must submit uninsured medical expenses to the Friend of the Court within 1 year of the date that the expense incurred.

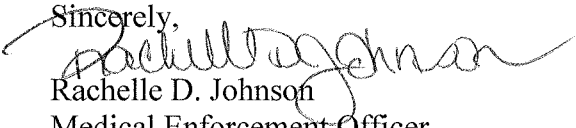
You will also need to fill out the area that indicates Requesting Party's Statement on the Complaint for Enforcement of Health Care Expense Payment form. By completing this form you are swearing to the court that the obligated parent did not make any payment to you or the medical provider.

After completing both sets of forms, please send the forms and the bills/receipts to the F.O.C. for further processing. 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. The Friend of the Court will contact you around that 21-day period to see if payment has been received. If the Obligor failed to remit payment then a

medical arrears account will be establish and the obligor will have to make payment on this account through our office.

Please contact me if you have any questions or if you need assistance in filling out the form.

Sincerely,

  
Rachelle D. Johnson  
Medical Enforcement Officer

04/07

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSE PAYMENT</b>	<b>CASE NO.</b>
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Friend of the Court address Telephone no.

Plaintiff

v

Defendant

**TO:**

Obligor's name and address

**Notice to Obligor:**

Under MCL 552.511a, the friend of the court has been asked to enforce the health care expenses described below. 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 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.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Friend of the court/Authorized representative

**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 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 minimum amount my order requires for enforcement.
3. This complaint is
  - 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.
  - within 6 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 \_\_\_\_\_ and \_\_\_\_\_  
Name(s) of child(ren) Name(s) of medical provider(s)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>REQUEST FOR HEALTH CARE EXPENSE PAYMENT</b>	<b>CASE NO.</b>
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Friend of the 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 insurance has paid on the expenses or the date insurance denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, 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: 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); or 6 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.

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

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 obligor at his or her last known address.

Date \_\_\_\_\_ Signature \_\_\_\_\_

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