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

The Friend of the Court (FOC) will assist you with ONLY the bills that accrued within one year from the date the expense was incurred, or within six months after the date of the insurance company's final payment or denial of coverage. The FOC will make every effort to make sure that each parent meets his or her court ordered obligation to pay the allocated uninsured health care expenses. The parent seeking the service will be responsible for payment of the expenses to the provider of the services. The FOC will enforce the other parent's financial responsibility if the following process is followed.

1. To request payment, you must complete the **Request for Health Care Expense Payment** form and send it to the other party*. Each expense must be itemized and written individually by the date of service, provider, and child. In addition, you must also provide copies of the bills. The bills attached should include the following information:

    - The name of the child receiving the services
    - The name of the provider
    - The date of service
    - The nature of the service
    - The cost of the service
    - Explanation of benefits from insurance providers showing what was paid or rejected and/or a copy of complete billing statement showing what was paid and who paid the payment
    - Copy of signed orthodontic contract, if applicable

2. Sign the Request for Health Care Expense Payment form and write the date you are sending the packet to the other parent.

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

3. Keep a copy of all the information provided to the other party, including the Request for Health Care Expense Payment form for future reference.

Instructions (Continued)

4. Allow the other parent **28 days** to pay you directly, or if you haven't paid the provider in full, they may pay the provider directly.

5. If the expenses haven't been paid by the other parent after 28 days, you then need to complete the Complaint for Enforcement of Health Care Expense Payment. To complete the Complaint for Enforcement of Health Care Expense Payment, you must fill in the Docket Number and Requesting Party and Receiving Party's names on the form. 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.

6. Attach a copy of the original Request for Health Care Expense Payment form and the bills and/or EOBs that you provided to the other party. The completed 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 the forms to (616) 632-6871 or email them to FOC.MAIL@kentcountymi.gov. ****Please note faxed or emailed copies must be full sized and legible. If emailed, please provide a pdf copy.**

Once the forms and supporting documentation are received by the FOC, the request will be processed, and a copy will be sent to each party showing what is owed. The FOC will hold on to the documents for 21 days to allow the receiving party the ability to object. If an objection is received within the allotted time, a motion will be filed with the Circuit Court and an objection hearing will be scheduled. If no objection if received, the expenses will be added to the account and the FOC will begin collection. If expenses are submitted by the payer of support the FOC may credit the account if there are any arrearages; or set up a new case and charge the payee.

If you have any further questions, please feel free to contact the Health Care Department at (616) 632-6888.

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
Foc.mail@kentcountymi.gov

Telephone number:
(616) 632-6888

REQUESTING PARTY	RECEIVING PARTY

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 or payment of coverage for the expense.

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/or Explanation of Benefits (EOBS) 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 (if available) 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.*****

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
Foc.mail@kentcountymi.gov

Telephone number:
(616) 632-6888

REQUESTING PARTY	V	RECEIVING PARTY

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 provided 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: _____

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
Foc.mail@kentcountymi.gov

Telephone number:
(616) 632-6888

REQUESTING PARTY	RECEIVING PARTY

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. This request is for
   (___) expenses that are more than the annual ordinary medical amount that can be collected as specified in the support order.
   (___) expenses incurred by the payor 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.

4. 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 provided 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 below, 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. A copy of your objection will be forwarded to the other parent and the Court.

I certify that on this date I served a copy of this complaint to on all parties or their attorneys of record by email, if available, or mail pursuant to MCR2.107(C).

_____ _____
Date Friend of the Court/Authorized Representative