EXPLANATION OF MEDICAL BILLS FORM

CASE CAPTION: _____ VS. _____ CASE NUMBER: _____

This form shall be used to organize a claim for reimbursement of medical, dental, optical, and psychological expenses which one parent has incurred and for which the other parent is partially responsible. Please use a separate form for each child and for each year. Submit this form to the other parent with copies of all bills, verification of the amount paid by the submitting parent (limited to a receipt for payment signed by the medical provider, a copy of a cancelled check, or a copy of a credit card statement verifying the amount paid by submitting parent) and insurance company explanation of benefits (EOB) forms. Be sure to keep a copy of the entire claim packet for your own records. In the event this form and the attachments need to be submitted to the Court, bring two complete copies (in addition to your copy) to the hearing.

NAME OF CHILD: _____

DATE OF SERVICE	SERVICE PROVIDER (Doctor, Dentist, etc.)	TOTAL BILL	AMOUNT PAID BY INSURANCE	AMOUNT PAID BY YOU AND DATE	DATE SENT TO OTHER PARENT	AMOUNT DUE FROM OTHER PARENT	AMOUNT OTHER PARENT PAID AND DATE	BALANCE DUE TO PROVIDER

SUMMARY: TOTAL AMOUNT DUE FROM OTHER PARENT: _____ LESS CASH MEDICAL SUPPORT (LINE 21f) = $_____