

Friend of the Court address
1697 Lansing Avenue, Jackson, MI 49202

Phone: 517-788-4470
Fax: 517-788-4683

Plaintiff's name and address	Requesting Party <input type="checkbox"/>

vs

Defendant's name and address	Requesting Party <input type="checkbox"/>

NOTICE TO REQUESTING PARTY:

If you are the custodial parent and your original or most recent court order was entered after October 1, 2004, and it includes an "annual ordinary medical" expense, you are not eligible for enforcement, in any given calendar year, until your out of pocket expenses meet or exceed the "annual ordinary medical" as established in your order.

This form is to be completed by the Requesting Party and sent to the Other Party, **before** presenting your bills to the Friend of the Court for enforcement. It is not necessary to provide the Friend of the Court with a copy of the Client Demand, unless the other party fails to respond to the demand in 28 days, and you want Friend of the Court to enforce the medical bills.

TO:

Other party's name and address

NOTICE TO OTHER PARTY:

Pursuant to the *Instructions for Filing the Client Demand for Medical Payment*, the requesting party (identified above) will provide a copy of this Demand for Medical Payment to the Friend of the Court, if you fail to reimburse the requesting party or respond to the requesting party within 28 days, from the date of mailing as indicated on page 2 of this Client Demand.

If you fail to respond to the requesting party within 28 days, the requesting party has been instructed to provide a copy of this Client Demand with medical bill(s) and explanation of benefit(s) attached, to Friend of the Court for further enforcement. Upon receipt of the Client Demand for Medical Payment by Friend of the Court, the Notice of Enforcement of Health Care Expenses is processed and mailed to you. This notice will clearly identify your respective portion due. If the office of the Friend of the Court does not receive a timely objection, enforcement resumes.

- For bills submitted by a **custodial parent**, enforcement actions include: adding the non-custodial parent's portion of the unpaid medical expenses to a medical reimbursement account; amending the non-custodial parent's income withholding to include the medical reimbursement account; or scheduling an order to show cause hearing.
- For bills submitted by a **non-custodial parent**, enforcement actions include: applying a credit to the non-custodial parent's account for a child support or other debt owed to the custodial parent; or scheduling a medical show cause hearing.

NOTICE TO BOTH PARTIES:

The Friend of the Court will deny a request for enforcement:

- If the requesting party cannot provide proof that they submitted a Client Demand to the other party within 28 days of the expense being incurred, or if insurance is involved, within 28 days of the insurance company's final payment or denial of coverage.
- If a request for enforcement is not submitted to the office within one year after the expense was incurred.
- If a requesting party did not take all measures necessary to submit a claim for the health care expense to all insurers that might be obligated to pay the expense within 2 months after the expense was incurred.
- If a complaint is not submitted to the office within six months after a parent defaults in paying for the health care expense as required under a written agreement, signed by both parents, that lists the specific bills covered by the agreement, the total amount to be paid, and the payment schedule.
- If the custodial parent does not provide proof that the "annual ordinary medical" has been satisfied, if your order provides for "annual ordinary medical".

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Plaintiff

vs

Defendant

Per our most recent court order dated _____, and based on the summary of bills listed, you are responsible for _____%, or \$_____.

Name of Child Receiving Service	Name of Provider Physician or Institution	* Date of Service	Nature of Service	Is Statement or Explanation of Benefits attached? (Yes or No)	Total Health Care Expense	Amount Paid By Insurance(s)	** Balance Due	Please Note: It is not necessary to provide FOC with a copy of this Client Demand, unless the other party fails to respond in 28 days, and you want Friend of the Court to enforce the medical bills.	
								Approved Or Denied	Amount Eligible for Reimbursement
* Your request for enforcement of health care expenses may be denied pursuant to 552.511a, if not submitted timely. ** Balance due: Balance owed after payment by insurance and <u>any adjustments</u> to the total medical cost.								Total	

*** STOP ***
 Do not write past this line - For Court use only

In compliance with Friend of the Court Procedures for Enforcement of Health Care Expenses, I am requesting payment from you within 28 days. If no response to my request is received within the 28 days, I will request Friend of the Court's assistance in collecting your portion of the uninsured health care expenses.

I declare the above statements of past-due medical, hospital, dental or optical bills for the minor child(ren) are the true amounts not covered by insurance, to the best of my information, knowledge and belief. I further confirm that, if "annual ordinary medical" has been ordered on our case that, I have met my minimum ordinary medical expense threshold for this calendar year, and that on this date I mailed a copy of this Client Demand for Medical Payment to the other party at his or her last known address.

I understand this Client Demand for medical payment may be returned to me if I fail to follow the proper procedure.

Date of Mailing: _____

Requesting Party Signature: _____