Instructions for Medical Reimbursement

This packet includes the following:

- Background information pertaining to medical expenses and reimbursement
- Instructions for the **CUSTODIAL** parent
- Instructions for the **NONCUSTODIAL** parent
- Request for Health Care Expense Payment form (FOC 13)
- Complaint and Notice for Health Care Expense Payment (FOC 13a)
- Health Care Expense Log

53rd JUDICIAL CIRCUIT COURT
FAMILY DIVISION
OFFICE OF THE FRIEND OF THE COURT

Cheboygan County Office
PO Box 70, Room 210
Cheboygan, MI 49721
(231) 627-8825 Main Line
(231) 627-8417 FAX
(800) 649-3777 TDD

KEVIN W. WELLER
Friend of the Court

Presque Isle County Office
PO Box 192
Rogers City, MI 49779
(989) 734-4312 Main Line
(989) 734-4995 FAX
(800) 649-3777 TDD

Information Regarding Uninsured Medical Expenses

The 2004 Michigan Child Support Formula Manual creates a new way to help parents pay for their child(ren)'s health care expenses. Each child support order issued or modified after October 1, 2004 will include an additional amount for "ordinary health care expenses." A person who pays support will pay an additional amount each month to cover a portion of the child(ren)'s ordinary health care expenses. This new process will help custodial parents pay out-of-pocket health care expenses as they incur them.

ORDINARY HEALTH CARE EXPENSES

Ordinary health care expenses include co-payments, deductibles and other uninsured health care costs. The base support already covers remedial care items such as band aids and non-prescription medications, so those expenses are not included in this category. The court order specifies an amount for ordinary health care expenses per child.

EXTRAORDINARY HEALTH CARE EXPENSES

For the custodial parent, health care expenses incurred on behalf of the child(ren) above the ordinary health care amount specified in the order are called Extraordinary Health Care Expenses. For the noncustodial parent, **ANY** health care expense incurred on behalf of the child(ren) is considered an extraordinary health care expense. The support order will indicate the percentage each parent must pay for extraordinary health care expenses.

The custodial parent should maintain an annual record of qualified ordinary health care expenses in case there are extraordinary health care expenses at some point in the calendar year. A Health Care Expense Log is available from the Friend of the Court for this purpose. Only one annual record needs to be maintained by the custodial parent regardless of the number of children on the case; ordinary medical expenses do not need to be documented on a separate expense log for each child.

To obtain a copy of your latest support order, please contact the County Clerk's office at 231-627-8808. Please contact the Friend of the Court office with any questions at 231-627-8825.

Anytime a bill is submitted for orthodontics/braces, you must attach copies of the actual contract that shows the total amount due. The contract should clearly state the expected insurance payment and the monthly payments you have arranged with the provider as well as any initial payment that is due immediately.

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Submission of Medical Bills for Reimbursement if you are the **Custodial Parent**

1) Please refer to your latest support order as to what the annual ordinary medical amount is that **you must first pay out of pocket. You may not seek reimbursement from the other party until you have reached that amount.** Your order should state $289 or $345 per child, per year, and have percentages that the Plaintiff and Defendant are responsible for. If the uninsured medical language is missing this process should be stopped immediately. Track the medical expenses your child(ren) has/have incurred, as you will need to supply the proof of payment of the annual ordinary medical amount. If you have further questions, please contact the Friend of the Court office.

If you need a copy of your latest support order, you must contact the County Clerk's office@ 231-627-8808. There may be a fee for this service.

2) Send the noncustodial parent by Certified Mail &/ Return Receipt (this shows there was proof of mailing to the other party):

a. Copy of the filled out Request for Payment form (FOC 13)
b. Copy of the proof that the yearly ordinary medical amount has been paid out of pocket
c. Copies of the Health Care Expense Log, medical bills and other accompanying documentation
d. Copy of your latest support order

**Be sure to keep a copy of the proof of mailing to the other parent, as you will need it if the Friend of the Court must start the enforcement process.*

If you and the other party come to an agreement on a payment plan, please submit the payment plan in writing to the Friend of the Court office. Both parties' signatures and the date must accompany the agreement. If an agreement is reached, there is no need for the Friend of the Court to start the enforcement process. If, after 28 days, an agreement is not reached, please continue with the instructions.

3) **If after 28 days** payment arrangements have not been made, send the following to the Friend of the Court office so we may start the enforcement process:

a. 2 copies of the proof of mailing
b. 2 copies of the proof of payment of the annual ordinary medical amount
c. 2 copies of the Request for Payment (FOC 13)
d. 2 copies of the Complaint (FOC 13a)
e. 2 copies of the Health Care Expense Log
f. 2 copies of all medical bills, Explanation of Benefits, receipts and other supporting documentation
g. 2 copies of your latest support order

The noncustodial parent will be given **21 days** to respond.

a. If the obligor submits the payment to the Friend of the Court office, we will make a copy of the check/money order and forward the payment on to you.
b. If the obligor submits the payment directly to you, we ask that you make a copy of the check/money order so we have proof of payment on file.
c. If there is no response from the obligor and the 21 day waiting period has passed, the medical expense amount will be added the support obligation.
d. If the obligor objects to the medical expense(s) within the 21 day waiting period, it will be set for a hearing. **Both parties** will be required to attend this hearing.

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Submission of Medical Bills for Reimbursement if you are the **Non-Custodial Parent**

Please refer to your latest support order as to what the Plaintiff's and Defendant's percentages are for uninsured health care expenses. If this language is missing this process should be stopped immediately.

1) Send the custodial parent by Certified Mail &/ Return Receipt (This shows there was proof of mailing to the other party):

a. Copy of the filled out Request for Payment form (FOC 13)
b. Copies of the Health Care Expense Log, medical bills and other accompanying documentation
c. Copy of your latest support order

If you need a copy of your latest support order, you must contact the County Clerk's Office @ 231-627-8808. There may be a fee for this service.

**Be sure to keep a copy of the proof of mailing to the other parent, as you will need it if the Friend of the Court must start the enforcement process.*

If you and the other party come to an agreement on a payment plan, please submit the payment plan in writing to the Friend of the Court office. Both parties' signatures and the date must accompany the agreement. If an agreement is reached, there is no need for the Friend of the Court to start the enforcement process. If, after 28 days, an agreement is not reached, please continue with the instructions.

2) **If, after 28 days,** payment arrangements have not been made, send the following to the Friend of the Court office so we may start the enforcement process:

a. 2 copies of the proof of mailing
b. 2 copies of the Request for Payment (FOC 13)
c. 2 copies of the Complaint (FOC 13a)
d. 2 copies of the Health Care Expense Log
e. 2 copies of all medical bills, Explanation of Benefits, receipts and other supporting documentation
f. 2 copies of your latest support order

The custodial parent will be given **21 days** to respond.

a. If the custodial parent submits the payment to the Friend of the Court office, we will make a copy of the check/money order and forward the payment on to you.
b. If the custodial parent submits the payment directly to you, we ask that you make a copy of the check/money order so we have proof of payment on file.
c. If there is no response from the custodial parent and the 21 days have passed, the custodial parent will have a medical reimbursement account set up through our office.
d. If the custodial parent contests the medical expense(s) within the 21 day waiting period, it will be set for a hearing. **Both parties** will be required to attend this hearing.

Approved, SCAO

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

STATE OF MICHIGAN 53rd JUDICIAL CIRCUIT CHEBOYGAN COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Friend of court address

PO BOX 70, ROOM 210, CHEBOYGAN, MI 49721

Telephone no.

(231) 627-8825

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.

Approved, SCAO

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

STATE OF MICHIGAN 53rd JUDICIAL CIRCUIT Cheboygan COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Court address
870 S Main St P O Box 70, Rm 210 Cheboygan , MI 49721

Telephone no.
231-627-8825

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 _____ and _____.
   Name(s) of child(ren) 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

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

HEALTH CARE EXPENSE LOG

NAME OF CHILD	MEDICAL PROVIDER	DATE OF SERVICE	TYPE OF SERVICE	TOTAL MEDICAL COST	AMT. PAID BY INSURANCE	BALANCE DUE*	OBLIGOR'S PERCENT	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.