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

STATE OF MICHIGAN 7th JUDICIAL CIRCUIT GENESEE COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Plaintiff	v	Defendant

TO:

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 Providers

_____ _____
Date Signature

Seventh Judicial Circuit of Michigan

Genesee County Friend of the Court

John G. Battles

Friend of the Court

Genesee County Admin Bldg.
1101 Beach St Suite 111
Flint, Michigan 48502-1474
Telephone: (810) 257-3300

Larry Leslie
Administrative Assistant

UNINSURED HEALTH-CARE EXPENSES

In order for the Friend of the Court to assist you in seeking reimbursement for uninsured medical expenses you have incurred on behalf of your minor child(ren), the following procedure must be followed:

1. A copy of all uninsured medical bills must be sent to the opposing party first; and, you must allow the other party a reasonable period of time to resolve the issue. If the issue remains unresolved after 28 days, enforcement by Friend of the Court may be requested by using the following procedure below:

   Complete the ATTACHED FORM and provide **PHOTOCOPIES OF EACH BILLING STATEMENT/RECEIPT.** Every statement/receipt must contain the following information:

   - DATE OF SERVICE
   - FEE/AMOUNT CHARGED
   - NAME OF HEALTH CARE PROVIDER
   - NAME OF PATIENT (CHILD)
   - TYPE OF SERVICE (FLU, BROKEN ARM, COUNSELING, ETC.)
   - **CANNOT INDICATE "BALANCE OWING" WITH NO ACCEPTABLE PROOF OF PAYMENT BY YOU (e.g., you cannot indicate, in your handwriting, that you paid a certain amount with check number "x" on statements, etc.)**
   - IF FOR ORTHODONTICS, THE ORTHODONTIA CONTRACT MUST BE SUBMITTED
   - EACH MEDICAL BILL/STATEMENT SHOULD INDICATE THE AMOUNT SUBMITTED TO, OR PAID BY, THE INSURANCE CARRIER AND/OR THE AMOUNT BILLED TO, OR PAID BY THE PARENT

   AN INSURANCE COMPANY EXPLANATION OF BENEFITS IS NOT AN ACCEPTABLE BILLING STATEMENT**.**

   THIS OFFICE HAS CONVERTED TO A PAPERLESS SYSTEM. THEREFORE, ANY MEDICAL BILL/RECEIPT, ORIGINAL OR COPY, WILL BE DESTROYED BY THIS OFFICE ONCE IT HAS BEEN SCANNED INTO OUR SYSTEM, THEREFORE, PLEASE SUBMIT "COPIES". ALSO, PLEASE DO **NOT** USE HIGHLIGHTER ON THE BILLING STATEMENTS AS IT WILL BE ILLEGIBLE ONCE IT HAS BEEN SCANNED INTO OUR SYSTEM.

   Most recent court orders indicate that the custodial parent must meet an annual ordinary medical amount each year before the other party is responsible for his/her percentage, therefore, please take this into consideration. However, if you are the non-custodial party that is submitting the uninsured medical expenses, the custodial party will not have to meet the annual ordinary medical amount.

   Upon receipt of uninsured medical expenses that include acceptable proof of payment by the complaining party, the Friend of the Court will enforce the uninsured medical expense issue pursuant to the controlling court order. Further, the Friend of the Court must submit a notice to the responding party indicating the amount that the complaining party has incurred "out-of-pocket"; and, what the responding party's share is toward those "out-of-pocket" expenses (uninsured medical expenses paid by the complaining party). The required notice is submitted to the responding party and must include copies of all paid uninsured medical expenses; and, the responding party is allowed 21 days to resolve the issue directly with the complaining party. If the matter remains unresolved after 21 days, then the Friend of the Court can administratively add the responding party's share toward the uninsured medical expenses to the child account as an arrearage if the responding party is the payer of support. If the complaining party is the payer of support, the Friend of the Court can administratively credit the child support account in the amount owing by the responding party. The amount that is administratively added to the "medical reimbursement" account will be collected as an arrearage (meaning, the amount(s) owing will not be collected in one lump sum).

   PLEASE BE ADVISED THAT THE FRIEND OF THE COURT IS NOT A COLLECTION AGENCY FOR HEALTH CARE PROVIDERS. THE FRIEND OF THE COURT ONLY ENFORCES ISSUES WHEREBY MONEY IS OWING TO ONE PARTY BY THE OTHER PARTY. PLEASE KEEP THIS IN MIND WHEN ENTERING INTO AN ORTHODONTIA CONTRACT WHEREBY THE UNINSURED ORTHODONTIA EXPENSES CAN BE EXTREMELY EXPENSIVE. IF YOU ARE THE PARTY THAT SIGNS THE ORTHODONTIA CONTRACT, THEN YOU ARE CONTRACTUALLY OBLIGATED TO PAY THE UNINSURED ORTHODONTIA EXPENSES TO THE ORTHODONTIST.

   ***PURSUANT TO MICHIGAN LAW*, NO UNINSURED MEDICAL EXPENSE WILL BE ACCEPTED/ENFORCED BY THIS OFFICE IF THE DATE OF SERVICE IS OLDER THAN THE PRECEDING ONE (1) YEAR, or if the date of service was prior**

to the first order requiring health care reimbursement. If you have uninsured medical expenses whereby the date of service is older than the preceding one year, you will have to petition the Court regarding same.

Attached are the receipts/statements, WITH PROOF OF PAYMENT, that support the uninsured medical expenses incurred on behalf of the minor child(ren):

PATIENT'S (CHILD'S) NAME	NAME OF HEALTH CARE PROVIDER	DATE OF SERVICE	NATURE OF SERVICE	TOTAL OF HEALTH CARE COST	AMOUNT PAID BY INSURANCE	TOTAL UNINSURED EXPENSE AMOUNT

BY SIGNING THIS COMPLAINT, YOU HEREBY STATE THAT YOU HAVE PROVIDED THE OTHER PARTY WITH THE ATTACHED UNINSURED MEDICAL EXPENSES; AND, ALLOWED THE OTHER PARTY 28 DAYS TO RESPOND, HOWEVER, THE OTHER PARTY HAS FAILED TO RESPOND WITHIN THE 28 DAY PERIOD:

SIGNED: _____ **CIVIL CASE NO.:** _____

(YOUR SIGNATURE)

_____ **DATE:** _____

COMPLAINANT'S NAME

ADDRESS: _____ **YOUR PHONE #'S:**

CITY/STATE/ZIP _____ **HOME:** _____ **CELL** _____

COMPLAINT AGAINST:

TELEPHONE #'S:

_____ **HOME:** _____ **CELL** _____

NAME OF OTHER PARTY

ADDRESS: _____ **EMPLOYER'S NAME & ADDRESS:**

CITY/STATE/ZIP _____ _____

_____ _____