Uninsured Health Care Expense Reimbursement Process

The Friend of the Court can help with the reimbursement of health care expenses that are less than one year old 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 as long as all measures necessary to submit the claim to insurance were completed within 2 months after the expense was incurred.

All bills must be submitted to all available insurance before submitting to the other party or the FOC for reimbursement.

If you are the recipient of child support, review your court order to determine if you are required to meet an annual ordinary medical threshold amount before you can seek reimbursement. Your court order will also tell you what percentages both you and the other party are required to pay for uninsured health care expenses.

If you are seeking reimbursement for orthodontic care you can submit the Request for Healthcare Expense form after signing the contract and making a down payment. You do not have to wait until you have paid off the braces in full. You will need to deduct the annual ordinary medical amount off for each year you are making payments.

If you are the payer of child support, you will not have to meet an annual ordinary medical threshold amount before seeking reimbursement.

Complete the Request for Healthcare Expense Reimbursement form. Be sure to fill out the whole form. You must provide copies of the bills. The bills must contain the following information:

*The name of the child receiving the service
*The name of the provider
*The date of service
*Type of service
*Total cost of service
*Amount paid by insurance
*Orthodontic contract, if applicable

Organize your expenses by date, earliest to latest, and list each one separately on the form. Your bills should also be in same order.

Sign and date the certificate of mailing. The date should be the date it is put in the mail.

Mail a copy of the Request for Healthcare Expense Reimbursement form and copies of the bills to the other party. If the other party's address is confidential you can submit the forms and bills to the FOC to mail for you. The other party has 28 days to pay you directly.

If the other party does not pay you directly within 28 days you can submit a copy of the Request for Healthcare Expense form along with copies of the bills to the FOC **AFTER** 28 days from the date the certificate of mailing was signed. The forms can be dropped off at the FOC window or mailed to: EATON COUNTY FRIEND OF THE COURT, 1045 INDEPENDENCE BLVD, CHARLOTTE, MI 48813. WE ARE NO LONGER ACCEPTING EMAILED OR FAXED FORMS.

Upon receipt of the appropriate form and bills, the FOC will process the request and a Complaint and Notice for Health Care Expense will be mailed. If a written objection if filed within 21 days of the date on the Certificate of Mailing, a Referee Hearing will be scheduled. If no objection is filed, the FOC will set up a medical reimbursement account and enforce.

If you have any questions regarding the process please contact the medical caseworker at 517-543-6850 Ext. 1313.

REQUEST FOR HEALTH CARE EXPENSE REIMBURSEMENT

Docket Number:_____

Requesting Party's name, address and phone	**Other Party's name, address and phone**

NAME OF CHILD RECEIVING SERVICE	NAME OF MEDICAL PROVIDER	DATE OF SERVICE	TYPE OF SERVICE	Total Medical Cost	Amount Paid by Insurance	Balance After Insurance Payment

The above expenses have been incurred for the health care of the minor child/children for whom you are obligated to provide health care support. Please make payment within 28 days from the mailing date below. If payment Is not received this form will be sent to the Friend of the Court for enforcement.

I declare that the above statements are true amounts not covered by insurance 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 Reimbursement to the other party at their last known address.

_____
Date

_____
Signature

Total
Subtract Annual Ordinary Medical
Balance
Multiply by Percentage
Amount Owed