INSTRUCTIONS FOR FILING FOR ENFORCEMENT COLLECTIONS OF UNINSURED HEALTH CARE EXPENSES

You have requested the assistance of the Office of Friend of the Court (FOC) to collect or obtain reimbursement for health care expenses. The FOC cannot act as your attorney, but will try to assist you to resolve this matter if you provide the necessary information in the proper manner, as explained here.

COURT ORDERED MEDICAL:

- Your court order states specifically each parent's obligation regarding medical support for the child(ren).
- Most orders say that one or both parents are to provide health care insurance for the child(ren) if available at a reasonable cost.
- Each parent must pay a percentage of the medical bills not covered by insurance, this includes co-pays and deductibles. It is written in your order what your percentage (%) is.
- Your order may also state that the person who receives the child support payments must pay a standard amount before requesting reimbursement of medical bills. Based on your order, this amount may be $289.00, $345.00 or $357.00 or $403.00 per child per year and is called Ordinary Medical Expense (OME).
- The person that pays medical support does not have to pay a standard amount before requesting reimbursement for medical bills.
- The person requesting reimbursement of medical bills must use the correct Friend of the Court forms. There are 2 forms. The first form is to list all the medical bills, expenses and insurance payments. The second form is to request Friend of the Court enforcement. These forms can be found on our web-site at https://www.co.midland.mi.us/FriendoftheCourt or you may request the forms be mailed to you.
- Always keep your copies, if you request additional copies you will be charged $1.00 per page.
- If enforcement of orthodontics/braces is requested, a copy of the original contract made between the provider (dentist) and the person requesting reimbursement must be sent to the FOC. Monthly billing statements will not be accepted. You must also provide a copy of the letter that was sent to the other parent notifying them of the services before the contract was signed.
- For extraordinary medical expenses that will exceed 12 months' payment of the OME, the annual OME and the monthly medical support obligation may be suspended by the FOC for the duration of the long-term reimbursement. (e.g., orthodontia, surgery). The monthly medical support obligation and the ordered OME will be prorated based on the date the request is received by the FOC.
- The "minimum enforcement threshold" under MCL 552.511a(1)(b) for additional medical expenses is $100 per child each calendar year, or a lower amount set by the court. If unreimbursed additional expenses do not exceed the threshold before a year ends, those expenses may be submitted to the FOC for enforcement on or after December 1st of that calendar year.

Step 1:

Notify the other person first by sending them the completed and signed ***Request for Health Care Expense*** form and provide copies of all bills and all explanation of benefits received by the insurance company.

All bills must have the following information:

- the name of the child(ren) receiving service;
- the name and address of the health care provider;
- the date of service;
- the nature of the service(s) provided;
- the cost of the service.

You must submit original bills or copies of the bills. Creditor notices are not acceptable. **If the child(ren) is covered by insurance, you must also send a copy of the explanation of benefits from the insurance company.**

You must send your request for payment to the other person within 28 days of either the receipt of the explanation of benefits from the insurance company, or if no insurance, within 28 days from the date of service.

Step 2:

The person that is asked to pay must send the payment directly to the asking party or arrange a direct payment plan within 30 days from the request.

The person that owes the payment that willfully neglects to respond/or send payment without valid objection may be assessed Court costs up to $250.00.

Step 3:

If payment or payment arrangements are not received after 30 days, the person requesting payment may then ask the Friend of the Court to enforce collection.

The person requesting payment must send all the same copies to the Friend of the Court as they sent to the other person as in Step 1 (above). They must also complete, sign and send the *Complaint for Enforcement of Health Care Expenses Payment (FOC13a)* form.

The FOC will make every effort to see that each parent pays his or her fair share of these expenses. However, your cooperation in providing the required information is crucial. The FOC needs this information to properly assist you to determine which party is responsible for payment. If the request is not submitted properly, it will be returned to you. Always keep a copy of each bill. Have your copies made before you submit your bills. If copies are requested from the FOC, a charge of $1.00 per page will be assessed.

All bills must be submitted to the FOC in the proper format within 1 year from the date of service. Bills for health care costs not covered by insurance should be submitted to the FOC within 6 months from the date of service.

The FOC will not accept bills over 1-year-old from the original date of service.

STATE OF MICHIGAN 42ND JUDICIAL CIRCUIT MIDLAND COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court, 220 W. Ellsworth St. 4th Floor, Midland, MI 48640 **phone. (989) 832-6801**

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 insurance has paid on the expenses or the date insurance denies payment, or if no insurance is applicable, within 28 days of billed services.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, 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 within the earliest of: within 1 year from the date of service where insurance is applicable; health care expenses not covered by insurance should be submitted to the FOC within 6 months from the date of service or 6 months after a default in a repayment agreement as set forth above. **The FOC will not accept bills over 1-year-old from the original date of service.**
6. In the event it is necessary for the friend of the court to enforce payments 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

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

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid/Adjusted by Insurance	Balance After Insurance/Adj

	Total Medical Cost	Amt. Paid/Adjusted by Insurance	Balance	Annual Ordinary Medical	% per Order	Amount Owed

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 the Request for Health Care Expense Payment to the obligor at his or her last known address.

_____ _____
Date Signature

NAME OF CHILD RECEIVING SERVICE	NAME OF MEDICAL PROVIDER	DATE OF SERVICE	TYPE OF SERVICE	TOTAL MEDICAL COST	AMOUNT PAID BY INSURANCE (INCLUDING DISCOUNTS ADJUSTMENTS)	BALANCE AFTER INSURANCE PAYMENTS/ADJUSTMENT/ DISCOUNTS

Total Medical Cost	Amt. Paid/Adjusted by Insurance	Balance	Annual Ordinary Medical	% per Order	Amount Owed