Original – Friend of the Court

STATE OF MICHIGAN 13th JUDICIAL CIRCUIT ☐ Antrim COUNTY ☐ Grand Traverse ☐ Leelanau	COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court Address
328 Washington Street, Suite 200, Traverse City, MI 49684

Telephone Number
(231)922-4660

Plaintiff's name	V	Defendant's name
TO: Name of person from whom reimbursement is sought (obligor):		

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 6 months after the date of the insurer's final denial of coverage for the expense.
   ☐ within 1 year of the date the expense was incurred.
   ☐ within 6 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

   $_____ and the balance owed to me is $_____.

I declare that the above statements are true to the best of my information, knowledge and belief.

_____ Date

_____ Signature

For FOC use only.

Notice to Obligor:

Under MCL 552.511a the Friend of the Court has been asked to enforce the health care expenses described below. Unless you file a written objection with the Friend of the Court **within 21 days of the date** provided in MCL 552.611, the expenses will be added to your support account as a health care support arrearage and enforced. 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 mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

_____
Friend of the Court/Authorized Representative