Original - Obligor

1st copy – Requesting Party
2nd copy – For Future Enforcement
(You must retain a copy of this completed form and all medical bills and receipts if you want enforcement by Friend of the Court.)

STATE OF MICHIGAN **13th JUDICIAL CIRCUIT** ☐ **Antrim COUNTY** ☐ **Grand Traverse** ☐ **Leelanau**	**REQUEST FOR 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, address, telephone no.	V	Defendant's name, address, and telephone no.

TO: Name and person from whom reimbursement is sought:

The following expenses have been incurred for the health care of your minor child:

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt Paid by Insurance	Amt Paid by Me	Balance Due

Total uninsured medical:

_____|

Obligor's percentage of medical:

_____%|

Balance due from obligor:

_____|

For FOC use only.

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, together with the copies of bills and receipts and proof of insurance payment to the obligor at his or her last known address.

_____
Date

_____
Moving party's signature (PLEASE ALSO PRINT NAME)