

# Health Care Reimbursement Claim Form

Rev. 4/09

This form shall be used to organize a claim for reimbursement of medical, dental, optical and psychological expenses which one parent has incurred and for which the other parent is partially responsible. Please use a separate form for each child. Use a separate form for each year. If appropriate more than one claim may be made in a single year but do not include claims for more than one year on each form. Be sure to deduct the \$100 per child per year amount which is the responsibility of the residential parent

Before a motion is filed alleging failure to pay medical bills, the claim for reimbursement must be submitted to the parent from whom reimbursement is sought. Submit this form to the responsible parent with copies of all bills and insurance company explanation of benefits forms. Be sure to make a copy of the entire claim packet. The claim should be submitted by some method by which receipt can be verified.

If a motion is filed bring two complete copies of the claim with all attachments to the hearing.

Name of child \_\_\_\_\_

Year \_\_\_\_\_

DATE OF SERVICE	NAME OF SERVICE PROVIDER	TOTAL BILL	AMOUNT PAID BY INSURANCE	AMOUNT PAID BY YOU	AMOUNT PAID BY FORMER SPOUSE	AMOUNT UNPAID
<b>TOTAL:</b>						

### SUMMARY OF CALCULATIONS

Total annual amount of unpaid	\$ _____
Minus \$100 per child per year	\$ _____
Subtotal	\$ _____
% of obligor's share	_____
Net amount of Claim (Subtotal multiplied by %)	\$ _____

You may make additional copies of this form

Date claim submitted to other parent \_\_\_\_\_