THIRD JUDICIAL CIRCUIT COURT

FRIEND OF THE COURT

COMPLAINT FOR HEALTH CARE EXPENSES

USE THIS SET OF FORMS IF:

- You have submitted health care bills to all insurance coverage available and there remain uninsured health care expenses
- The uninsured health care expenses accrued within the last year
- You have sought reimbursement from the other party and 28 days have lapsed without payment

INSTRUCTIONS FOR COMPLAINT FOR HEALTH CARE EXPENSES

BEFORE YOU FILE A COMPLAINT FOR HEALTH CARE EXPENSES:

You must first use all insurance available to you before submitting bills to the other parent or a Complaint for Health Care Expenses to the Friend of the Court. If the other party alleges that these bills have not been submitted to all available insurances, you will be required to prove to the Court that all insurance has been billed.

You must notify the other parent of the expense by providing a copy of the bills and/or proof of payment. That parent is expected to pay you or the provider according to the percentage in the most recent child support order. **This is done directly between the parties**. If he or she does not pay you directly within 28 days after being presented with the bills, you may submit a Complaint for Health Care Expenses. If you are unable to provide the other party with copies of bills and/or health insurance denial due to a confidential address, you may submit a Complaint for Health Care Expenses and the Friend of the Court will serve the other party.

MINIMUM CRITERIA TO FILE A COMPLAINT FOR HEALTH CARE EXPENSES:

Friend of the Court will assist you ONLY with bills that date back one year from the date you signed the Complaint for Health Care Expenses. The accrual date is the date of service, not the billing date. A motion must be filed for all bills that accrued more than one year ago.

Friend of the Court will only enforce uninsured health care expenses that exceed $100.00.

Check your most recent child support order to determine if you are the payee (or recipient) or payer of support.

- **If you are the payee of support,** you must pay the annual ordinary medical amount listed in your child support order and provide proof of payment. The Friend of the Court will only enforce payment of health care expenses that exceed the annual ordinary medical amount and have been paid. You must provide proof that the annual ordinary medical amount has been paid in order for the Friend of the Court to assist with enforcement. Failure to provide proof of payment will result in your complaint being rejected.
- **If you are the payer of support,** you do not need to pay the annual ordinary medical amount in order to file a Complaint for Health Care Expenses because your contribution is included in your monthly child support obligation.

If your expenses do not qualify for the Complaint process, you may file a motion through your own attorney, or acting as your own attorney (in pro per) to bring the matter before the Court. Friend of the Court cannot assist you with filing any motion.

HOW TO FILL OUT THE FORM:

1. Fill out pages 1 through 3. **USE BLACK OR BLUE INK ONLY.**
2. Write your Case Number in the upper right corner of every page.
3. Attach a complete copy of your most recent child support order.
4. The PLAINTIFF is the person who originally filed the case. The DEFENDANT is the party against whom the case was originally filed. This information is in your court order.
5. The OBLIGOR is the person who has not paid his/her share of the child(ren)'s health care expenses. The OBLIGEE is the person who paid out of pocket or carries the debt of the child(ren)'s health care expenses.
6. Organize and attach your expenses by date, earliest to latest, and LIST EACH ONE on the form in order. DO NOT attach the forms without listing the expenses in the Complaint form. These will not be accepted. **You must provide:**
   a. Date of service;
   b. Name and address of health care provider;
   c. Service or product provided;
   d. Patient's name (this must be the child(ren) of this case); and
   e. Amount you paid or were billed <u>for that specific date and service</u>. We will NOT consider any previous balances.
7. The following documentation <u>**will not**</u> be accepted:
   a. Explanation of Benefits forms. You must provide the actual bills.
   b. Invoices from your Health or Flex Spending Accounts. You must provide the actual bills.
8. DATE AND SIGN THE FORM.

Caution: If you submit a <u>patient ledger</u> as proof of health care expenses it must contain all the information that the Friend of the Court requires as stated above. Highlight or underline the specific expenses.

YOU MAY SUBMIT YOUR COMPLAINT FOR HEALTH CARE EXPENSES TO THE FRIEND OF THE COURT BY MAIL, EMAIL, OR FAX AS FOLLOWS:

Mail to: Wayne County Friend of the Court, Medical Department, P.O. Box 31-2660, Detroit, MI 48231-2660

Email to: Medical@3rdcc.org

Fax to: (313) 237-9315
We do not recommend faxing Complaints. Fax copies of bills are often very hard to read. If we cannot read them, they will be returned to you.

WHAT YOU CAN EXPECT FROM THE FRIEND OF THE COURT AFTER SUBMITTING A COMPLAINT FOR HEALTH CARE EXPENSES

1. The Friend of the Court will review the Complaint for Health Care Expense and check the following:
   a. All bills submitted are within one year of the signing of the Complaint for Health Care Expense. All bills outside of the one year will not be considered.
   b. If you receive support, the Friend of the Court requires verification that the annual ordinary amount has been paid. If you do not provide proof that you have paid the annual ordinary medical amount, the entire Complaint for Health Care Expenses will be rejected.
   c. If you are the payer of support, you will not need to spend the annual ordinary amount.
   d. All bills submitted have been provided to the other party AND 28 days have lapsed with no resolution.
   e. The Health Care Expense is at least $100.
   f. That all bills are attached to the Complaint for Health Care Expense.

2. The Friend of the Court will calculate the Complaint for Health Care Expense to determine the other parties' share of the expenses.

3. A Complaint for Health Care Expense, Notice of Enforcement of Health Care Expenses and Objection form will be mailed to both parties informing them of the amount that will be added to the arrears on this case. The Notice will also inform the parties they may object to the Complaint and Notice of Enforcement by completing the enclosed objection form within 21 days from the date of mailing.
   a. If no objections are filed within 21 days, then an Order for Reimbursement of Uninsured Health Care Expenses will be entered by the Court and the amount will be added to the arrears subject to all enforcement remedies available to the Friend of the Court.
   b. If an objection is filed, then a hearing will be scheduled before the assigned referee. You will receive a notice of hearing with a date, time and hearing location.

Please allow 30 days to process your Complaint for Health Care Expenses

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	COMPLAINT FOR HEALTH CARE EXPENSES	CASE NO. HON.

Please print or type information

Plaintiff name, address, telephone no., and email address	Defendant name, address, telephone no., and email address
Attorney name, address, telephone no., and email address	Attorney name, address, telephone no., and email address
☐ This party is incarcerated	☐ This party is incarcerated
_______________ Prisoner ID# _______________ Department of Corrections' Prison Name	_______________ Prisoner ID# _______________ Department of Corrections' Prison Name

I request the Friend of the Court 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 from the obligor within 28 days of the date notified of the balance due after insurance payments and have not received payment; or
   ☐ I did not request payment from the obligor as his/her address is confidential.

2. The request is submitted by
   ☐ The payee of support and the expenses exceed the annual ordinary amount by $100.00 and can be collected as specified in the support order; or
   ☐ The payer of support and have incurred health care expenses for our child(ren).

3. This complaint is
   ☐ within six months after the date of the insurer's final denial of coverage;
   ☐ within one year of the date the expense was incurred (date of service or purchase); or
   ☐ within six 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 $__________ for ______________________________ and
   Name(s) of child(ren)
   ______________________________.
   Name(s) of medical provider(s)

_______________________ Date

_______________________ Signature of Obligee

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	COMPLAINT FOR HEALTH CARE EXPENSES	CASE NO. HON.

Date of Service	Physician/Provider	Child	Total Cost	Amount paid by insurance	Amount paid by Obligee	Balance due Provider

I declare that the above (and any attached) statements of past-due health care expenses for the minor child(ren) are the true amounts not covered by insurance to the best of my information, knowledge and belief.

_________________________ Date

_________________________ Signature of Obligee

This section for Friend of the Court use only

Total health care cost not paid by insurance: $ ___________

Minus applicable annual ordinary health care cost: $ ___________

Percentage to be paid by obligor per judgment: ___________ %

Total amount due obligee and providers by obligor: $ ___________

GRAND TOTAL (of all forms) $___________

Date of mailing by court: ___________

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FOC Rep:

Phone:

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	COMPLAINT FOR HEALTH CARE EXPENSES	CASE NO. HON.

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I declare that the above (and any attached) statements of past-due health care expenses for the minor child(ren) are the true amounts not covered by insurance to the best of my information, knowledge and belief.

______________________________ Date

______________________________ Signature of Obligee