
Gerald M. Prill
Circuit Judge

STATE OF MICHIGAN

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Friend of the Court



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52ND CIRCUIT COURT
FAMILY DIVISION
OFFICE OF THE FRIEND OF THE COURT

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Uninsured medical expenses are governed MCL 552.511a as well as §3.04 of the Michigan Child Support Manual.

The enclosed forms must be used when requesting reimbursement of these expenses. In order for the Friend of the Court office to assist in collection of uninsured medical expenses, each step on the form must be followed. These steps are outlined under "*INSTRUCTIONS FOR REQUESTING PARTY*". Failure to complete each step will result in the forms being returned to you unprocessed.

UNINSURED MEDICAL/HEALTH CARE EXPENSE REIMBURSEMENT PROCESS

Instructions to Requesting Party

What is an eligible medical/health care expense?

The term “medical” includes treatments, services, equipment, medicines, preventative care, similar goods and services associated with oral, visual, psychological, medical, and other related care, provided or prescribed by health care professionals for the children.

First, review your court order

You may have a provision in your court order for a monthly “ordinary medical expense” charge. If you do, you cannot seek medical/health care expense reimbursement from the other parent until the annual ordinary threshold amount has been spent. One way of thinking of this is as a deductible – you cannot seek reimbursement from your co-parent until you’ve spent the deductible. If your order does not have a charge for ordinary medical you do not have to meet the annual threshold. The annual threshold amounts are:

Number of Children	Annual Threshold*
1	\$454
2	\$908
3	\$1,362
4	\$1,816
5 or more	\$2,269

**2021 Guidelines*

Your order will also state what **percentage** of the uninsured expenses you are to pay and what **percentage** of the uninsured expenses your co-parent is to pay. You will need to know those percentages in order to complete the form.

Second, claims must first be submitted to all available insurance

Claims can only be submitted for **uninsured** expenses. You must first submit the bill to all available insurance before you submit it to your co-parent and the Friend of the Court.

Third, submit the Request for Health Care Expense Payment to your co-parent

Before seeking assistance from the Friend of the Court you must submit your reimbursement request to your co-parent. The request must be made within **28 days** of either the date insurance has paid (or denied) the claim.

Use the ***Request for Health Care Expense Payment form*** to request reimbursement from your co-parent. You must provide copies of the bills (not account or balance forward statements) showing the name of the child(ren) receiving the service, the date of service, a description of the service and the provider name/address. You must submit receipts or statements showing what you and/or insurance have paid, or that coverage has been denied.

If you and your co-parent 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 and, if enforcement by the Friend of the Court is requested, the agreement must be provided to the Friend of the Court.

Fourth, if your co-parent does not pay you, seek Friend of the Court enforcement

Complete the *Complaint for Enforcement of Health Care Expense*. You must also provide a copy of the *Request for Health Care Expense Payment* that you provided to your co-parent along with all bills, receipts for payment and insurance coverage or denials.

The medical bills must be submitted to the Friend of the Court on or before:

- 1 year after the expense was incurred;
- 6 months after the insurer's final payment or denial of coverage (as long as all measures necessary to submit the claim to insurance were completed within 2 months after the expense was incurred); or
- 6 months after a default in a repayment agreement.

Untimely bills will not be processed by the Friend of the Court.

If everything has been submitted properly, Friend of the Court will mail the *Complaint for Enforcement of Health Care Expense* to your co-parent who has an opportunity (21 days) to object and request a hearing. If no objection is received, the expenses will be added to the child support account.

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.
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Friend of court address Telephone no.

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 the insurance provider has paid on the expenses or the date the insurance provider denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, and the agreement must 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 on or before the following: one year after the expense was incurred, or six months after the insurer's final denial of coverage for the expense (as long as all measures necessary to submit the claim to insurance were completed within two months after the expense was incurred), or six months after a default in a repayment agreement as set forth above. You will need to fill out a second form to request enforcement.
6. In the event it is necessary for the friend of the court to enforce payment 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

Complete expenses incurred on the other side of this form.

I hereby attest that I have made a demand for payment as outlined above, that the other party has failed, refused and/or neglected to pay health-care expenses on behalf of the minor child(ren), and that it is necessary for the Friend of the Court to enforce payment of the expenses.

date

signature

Plaintiff

v

Defendant

CASE NO.

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 by Insurance	Balance Due*	Obligor's %	Amt. Owed by Obligor

*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.

Date

Signature

Plaintiff

v

Defendant

CASE NO.

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 by Insurance	Balance Due*	Obligor's %	Amt. Owed by Obligor

*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.

Date

Signature

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO. and JUDGE
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Court address _____ Court telephone no. _____

Plaintiff's name	v	Defendant's name
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TO: Obligor's name and address

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 six months after the date of the insurer's final denial of coverage for the expense.
 - within one year of the date the expense was incurred.
 - 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

NOTICE

The friend of the court has been asked to enforce health-care expenses. Unless you file a written objection with the friend of the court within 21 days of the date this notice is sent, the expenses will be added to your support account as a health-care support arrearage for enforcement and must be paid in full by _____. \$ _____ per month, except that the full balance will be subject to immediate enforcement.

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 served a copy of this complaint on the parties or their attorneys by first-class mail addressed to their last-known addresses as defined by MCR 3.203. I declare under the penalties of perjury that this certificate of mailing has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Date Friend of the court/Authorized representative