REQUEST FOR HEALTH CARE EXPENSE REIMBURSEMENT

Docket Number:_____

Requesting Party's name, address and phone	**Other Party's name, address and phone**

NAME OF CHILD RECEIVING SERVICE	NAME OF MEDICAL PROVIDER	DATE OF SERVICE	TYPE OF SERVICE	Total Medical Cost	Amount Paid by Insurance	Balance After Insurance Payment

The above expenses have been incurred for the health care of the minor child/children for whom you are obligated to provide health care support. Please make payment within 28 days from the mailing date below. If payment Is not received this form will be sent to the Friend of the Court for enforcement.

I declare that the above statements are true amounts not covered by insurance to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expense Reimbursement to the other party at their las known address.

_____ _____

Date Signature