# Uninsured Expense Reimbursement Form

To: _____

(The name of person who owes reimbursement)

_____

(The address of the person who owes reimbursement)

From: _____

(The name of person who is making the claim)

_____

(The address of the person who is making the claim)

Date mailed: _____ Date due from the other party: _____

Total due from the other party: $ _____ based on _____ % reimbursement obligation.

| Date of Service | Provider and Purpose | Medical | Prescription | Dental or Orthodontia | Vision |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Suggested Instructions**

1. Fill in all blanks including date of service, name of provider (i.e. doctor, dentist, etc.), the purpose (i.e. eyeglasses, illness, cleaning, etc.).

2. Fill in the amount paid out of pocket (amounts not reimbursed by any employer or insurance company) in the appropriate column of the table.

3. If possible, submit form to the other parent on a monthly basis with copies of billings.

4. Keep a copy of everything and document the date it was mailed to the other parent.

5. Keep copies of checks or credit card statements showing personal payment.

6. Make reimbursement to other party as directed in the court order or judgment.

7. Use additional pages if necessary. This form is intended to simplify the sharing of information when making claims for uninsured reimbursement.