EDWARD R. POST
CHIEF CIRCUIT JUDGE – TRIAL DIVISION

JON HULSING
CIRCUIT JUDGE – TRIAL DIVISION

JON A. VAN ALLSBURG
CIRCUIT JUDGE – FAMILY DIVISION

KENT D. ENGLE
CIRCUIT JUDGE – FAMILY DIVISION

MARK A. FEYEN
CHIEF PROBATE JUDGE – FAMILY DIVISION

STATE OF MICHIGAN

TWENTIETH JUDICIAL CIRCUIT COURT
OTTAWA COUNTY
FRIEND OF THE COURT

JENNELL L. CHALLA
FRIEND OF THE COURT

MATTHEW J. SCHMID
ASSISTANT FRIEND OF THE COURT

KATHY E. WINSTON
ASSISTANT FRIEND OF THE COURT

ENFORCEMENT OF UNINSURED HEALTH CARE EXPENSES

Any health care expenses subsequent to the entry of an Order or Judgment must **FIRST** be submitted by you directly to the other party in a timely manner. A dated letter must accompany the bills when you submit them to the other party.

If the other party has failed to make payment arrangements within 35 days, complete the enclosed demand for medical payment forms and return them to the FOC with the following; Bills/receipts containing the name of child(ren), date of service, reason for visit and amount. **You must provide a copy of the letter sent to the other party requesting payment.** If the bill is a result of orthodontic treatment, you must also include a copy of the orthodontic contract and a payment history.

THE BURDEN OF ESTABLISHING THE NECESSITY OF THESE EXPENSES WILL REST WITH YOU.

The total amount owed to you must be a minimum of $100.00 or the expense be 6 months old. **THE FRIEND OF THE COURT WILL NOT ENFORCE CLAIMS OVER 1 YEAR OLD.**

Our office cannot enforce payments to a third party (physician, dentist, etc.), however the other party may opt to make payment arrangements with a third party if there is a balance owing.

BE ADVISED – if all requested documentation is not submitted your "demand for medical payment" will be returned to you.

Checklist

Completed forms _____
Copy of each expense_____
Copy of letter sent to other party _____
Completed affidavit (if applicable) _____

Due to the volume of submissions, please allow 6 weeks for processing.

Ottawa County Friend of the Court
414 Washington Ave – Suite 225
Grand Haven, MI 49417

DEMAND FOR HEALTH CARE PAYMENT

(expenses other than orthodontic)

_____
Other Party's Name Case # _____

_____
Address

_____
City, State, Zip

LIST EACH EXPENSE SEPARATELY
IF YOU HAVE ORTHODONTIC EXPENSES COMPLETE FORM ON BACK

Child receiving service	Physician	Date of service	Reason for visit	Total cost by insurance	Amount paid	Balance due

I declare that the above statements are true to the best of my information, knowledge, and belief and that I mailed a copy of these expenses by ordinary mail to the other party at their last known address.

_____ _____
Date Signature

The above expenses have been submitted to the Friend of the Court for enforcement. To avoid further court action these expenses must be paid within 28 days. You must provide our office with proof of your payment to receive proper credit.

Do not write below this line - Friend of the Court use only.

Total medical cost not paid by insurance: **$_____**

Percentage owed by payer: **x _____%**

Total amount due: **$_____**

Date of mailing by court:

_____

DEMAND FOR HEALTH CARE PAYMENT - ORTHODONTICS ONLY!!

_____
Other Party's Name Case #_____

_____
Address

_____
City, State, Zip

For enforcement of orthodontic expenses you must include the following:
A copy of the orthodontic contract
An account summary showing all payments

Child receiving service	orthodontist	date contract began	total cost	amount paid by insurance	amount paid/ balance

I declare that the above statements are true to the best of my information, knowledge, and belie and that I mailed a copy of these expenses by ordinary mail to the other party at their last known address.

_____ _____
Date Signature

The above orthodontic expenses have been submitted to the Friend of the Court for enforcement. This notice is a demand for payment. Please contact the other party or the orthodontist and arrange for payment of these expenses within **14 days**.

Do not write below this line - Friend of the Court use only.

Total cost of orthodontics: $ _____

Monthly payment amount: $_____

Percentage owed by payer: _____%

Total amount owed by payer: $_____

_____
Date of mailing by court

Ottawa County Friend of the Court
414 Washington Ave. Rm. 225
Grand Haven, MI 49417

SAMPLE

DEMAND FOR HEALTH CARE PAYMENT

(expenses other than orthodontic)

Party who owes the money
Other Party's Name

Case # _____

_____
Address

_____
City, State, Zip

LIST EACH EXPENSE SEPARATELY
IF YOU HAVE ORTHODONTIC EXPENSES COMPLETE FORM ON BACK

Child receiving service	Physician	Date of service	Reason for visit	Total cost	Amount paid by insurance	Balance due/ amount paid
name	Dr. Smith	1/1/13	physical	100.00	20.00	80.00
Name	Dr. Doe	7/1/13	Fillings	200.00	100.00	100.00

I declare that the above statements are true to the best of my information, knowledge, and belief and that I mailed a copy of these expenses by ordinary mail to the other party at their last known address.

_____ ____**Your signature here** _____ __
Date Signature

The above expenses have been submitted to the Friend of the Court for enforcement. To avoid further court action these expenses must be paid within 28 days. You must provide our office with proof of your payment to receive proper credit.

Do not write below this line - Friend of the Court use only.

Total medical cost not paid by insurance: **$_____**

Percentage owed by payer: **x _____%**

Total amount due: **$_____**

Date of mailing by court:

_____

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AFFIDAVIT OF EXPENSES

_____
Name

_____
Case Number

I, _____, declare that health care expenses
(Print name above)

incurred on behalf of the minor child(ren) have exceeded $_____ which is the amount designated as "ordinary medical expenses". I have presented copies of these expenses to the other party.

I declare that the above statements are true and correct to the best of my information, knowledge and belief.

_____ _____
Date Signature

LIST THE EXPENSES ON THE BACK OF THIS PAGE.
(List expenses applied to ordinary medical allotment)

This form is to be used only if your order allows for "ordinary medical expenses"

Name	Date of expense	Reason for visit	Total	Balance due

Grand total _____