48th CIRCUIT COURT
ALLEGAN COUNTY FRIEND OF THE COURT

Telephone: 877-543-2660
Fax: 269-673-0322
www.allegancounty.org

PO Box 358
113 Chestnut Street
Allegan, MI 49010-0358

Michael J. Day, Circuit Court Administrator/Friend of the Court
Erin Stender, Deputy Friend of the Court
Jennifer L Kamps, Attorney/Referee

INSTRUCTIONS FOR FILING THE HEALTH-CARE EXPENSE PAYMENT AND COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT

The Friend of the Court (FOC) can ONLY assist you with bills that accrued within one year from the date the expense was incurred (date of service), or within six months after the date of the insurance company's final payment or denial of coverage.

The FOC will make every effort to ensure that each party meets his or her court ordered obligation to pay the allocated uninsured health-care expenses. The party who attends the medical appointment is responsible for payment of the expenses to the provider of the services. The FOC will enforce the other party's financial responsibility ONLY if the following process is followed.

1. Check to see if your court order requires the other party to pay a portion of health-care expenses. (This typically can be found on page 2 of your Uniform Child Support Order) The FOC will not enforce health-care expenses when there is a zero child support order.
2. Once an expense is incurred, you must request payment from the other party by completing the Request for Health-Care Expense Payment form and sending it to the other party within 28 days after the receipt of the last insurance payment or final denial from the insurance company.
3. Each expense must be entered on the second page(s) of the Request for Health-Care Expense Payment form in the chart and itemized.
4. You must also provide copies of the bills and insurance notifications. The bills attached to the Request for Health-Care Expense Payment form should include the following information:
    - The name of the child receiving the services.
    - The name of the health care provider.
    - The date of service.
    - The nature of the service.
    - The cost of the service.
    - Explanation of benefits from the insurance providers showing what was paid or rejected and/or a copy of complete billing statement showing what was paid and who paid.
    - Copy of signed orthodontic contract, if applicable.

5. Write your case number and the name of the Plaintiff and Defendant in the appropriate spaces.
6. Make a copy of all the information provided to the other party including the Request for Health-Care Expense Payment form. You will need to send this to the FOC if the other party does not pay you directly. (see number 10)
7. Once you have sent the Request for Health-Care Expense Payment form to the other party, you are required to allow the other party 28 days to pay you directly.

8. If after 28 days have passed and you have not received payment from the other party, you may file the Complaint and Notice for Health-Care Expense Payment with the Friend of the Court. Complaints must be filed with the FOC within one year from the date the expense was incurred (date of service), or within six months after the date of the insurance company's final payment or denial of coverage.
9. Fill out the Complaint and Notice for Health-Care Expense Payment completely, including Plaintiff and Defendant the other party's (Obligor's) name and address and make sure you sign and date the form. You are certifying the information on this form is accurate when you sign the form. The Complaint will not be processed if the form is not complete.
10. Attach a copy of the Request for Health-Care Expense Payment form and all the attachments to the Complaint and Notice for Health-Care Expense Payment. The form and attachments should be mailed to: Allegan Friend of the Court, PO Box 358, Allegan, MI 49010. (see number 6)
11. Once the Complaint and Notice for Health-Care Expense Payment (see item 8) along with the Request for Health-Care Expense Payment form along with all documentation (see item 10) is provided to the FOC, the bills will be processed, and a copy will be sent to each party showing what is owed along with an Objection form.
12. The FOC will wait 21 days to allow the party who is required to pay the right to object. If an objection is received within 21 days an objection hearing will be scheduled before the Referee. If there is no objection received the bills will be added to the account. If you are the person who receives child support the amount will be added to the other party's balance as arrears and if you are the person who pays child support you will receive a credit.

If you have any further questions, please feel free to contact the Allegan Friend of the Court at (877) 543-2660.

Approved, SCAO

Original - Obligor
1st copy - Requesting party
2nd copy - For court as needed

STATE OF MICHIGAN 48th JUDICIAL CIRCUIT Allegan COUNTY	REQUEST FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Friend of court address

113 Chestnut, PO Box 358, Allegan, MI 49010

Telephone no.

(877) 543-2660

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.

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
							0.00%	
							0.00%	
							0.00%	
							0.00%	
							0.00%	

*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
							0.00%	
							0.00%	
							0.00%	
							0.00%	
							0.00%	

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

Date

Signature

Approved, SCAO

Original - Friend of the court
1st copy - Obligor
2nd copy - Requesting party

STATE OF MICHIGAN 48th JUDICIAL CIRCUIT Allegan COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Court address
113 Chestnut Street, PO Box 358, Allegan, MI 49010

Telephone no.
(877) 543-2660

Plaintiff

v

Defendant

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 _____ (Name(s) of child(ren)) and _____ (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 certify that on this date 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 in MCR 3.203.

Date _____ Friend of the court/Authorized representative _____