

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	DEMAND FOR MEDICAL PAYMENT	CASE NO.
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Court address Court telephone no.

Plaintiff	v	Defendant
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RECEIPIENT'S INSTRUCTIONS FOR COMPLETING FORM:

You have requested the assistance of the Friend of the Court in the enforcement of payment of medical bills. If your court order provides for the payment of medical bills this office will assist you after you have completed this form in full. Mail all copies of the completed form to the Friend of the Court address above. A copy will be returned to you.

You must have supporting bills and receipts for the expenses you list. The burden of establishing these expenses and their necessity will rest with you. Please bring your documentation to all court hearings or meetings at the Friend of the Court where medical expenses may be discussed.

If you have not been contacted by the payer or Friend of the Court within 35 days of the mailing of this form, please notify the Friend of the Court that you wish additional action.

TO: Payer's name and address

The following expenses have been submitted to the Friend of the Court for enforcement. This notice is a demand for payment of the listed medical expenses. Please contact the custodian or physician and arrange for a payment plan within 14 days.

Child Receiving Service	Physician/ Institution	Date of Service	Nature of Service	Total Medical Cost	Amt. Paid by Insurance	Amt. Paid by Custodian	Balance Due

I declare that the above statements of past-due medical, hospital, and dental bills for the minor child(ren) are the true amounts not covered by insurance, to the best of my information, knowledge, and belief.

_____ Date

_____ Custodian's signature

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

Total medical cost not paid by insurance: \$ _____

Percentage to be paid by payer: x _____ % Date of mailing by court:

Total amount due custodian and physician by payer: \$ _____