Request for Unreimbursed Medical Expense for 20__

Expenses incurred for :_____(only one person per worksheet) Court Order Dated_____

Plaintiff's allocated share _____% Defendant's allocated share _____%

Date of Service	This bill covers the 1st $250.00/year (X)	Type of Service	Total Bill	Provider's Name In Network (Y/N)	Amount of Insurance Pmt	Balance Due
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					
_____	(___)					

TOTAL BALANCE = $

"B""To figure out other parent's obligation for unreimbursed medical expenses for first submission: subtract $250.00 or the prorated amount for the first calendar year of support from total balance on this page. Multiply new balance by percentage found in Court Order of support. (Example, total expense are $770.00 - $250.00 = $520.00 x 45% = $234.00).

BALANCE DUE BY OTHER PARENT = $_____

HEALTH INSURANCE COVERAGE INFORMATION MUST BE COMPLETED BY THE PERSON FILING FOR MEDICAL SUPPORT ENFORCEMENT – INDICATE WHO PROVIDES THE COVERAGE AND THE TYPE IN EFFECT FOR THE DEPENDANT NOTED ABOVE"

PLAINTIFF	( ) YES ( ) NO	IF YES, CHECK THE TYPE	( ) MEDICAL ( ) DENTAL ( ) VISION ( ) PRESCRIPTION
SPOUSE OF THE PLAINTIFF	( ) YES ( ) NO	IF YES, CHECK THE TYPE	( ) MEDICAL ( ) DENTAL ( ) VISION ( ) PRESCRIPTION
DEFENDANT	( ) YES ( ) NO	IF YES, CHECK THE TYPE	( ) MEDICAL ( ) DENTAL ( ) VISION ( ) PRESCRIPTION
SPOUSE OF THE DEFENDANT	( ) YES ( ) NO	IF YES, CHECK THE TYPE	( ) MEDICAL ( ) DENTAL ( ) VISION ( ) PRESCRIPTION
OTHER	( ) YES ( ) NO	IF YES, CHECK THE TYPE	( ) MEDICAL ( ) DENTAL ( ) VISION ( ) PRESCRIPTION

I, _____ verify that the facts set forth in the foregoing medical enforcement form, including all attachments thereto, are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA.C.S.A.§ 4904 relating to unsworn falsification to authorities. By submitting copies of medical bills and insurance claims, I am waiving any and all conditions of HIPAA regulations to DRS and the other party. Medical expenses and insurance claims will be retained by DRS and will not be released to outside agencies or third parties.
*If you fail to sign this waiver the DRS office will be limited to enforcement of health care coverage only and will not be able to enforce for collection of unreimbursed medical bills.

Date: _____ Signature _____