JON A. VAN ALLSBURG
CHIEF CIRCUIT JUDGE
FAMILY DIVISION / BUSINESS COURT

JON HULSING
CIRCUIT JUDGE – TRIAL DIVISION

KAREN J. MIEDEMA
CIRCUIT JUDGE – TRIAL DIVISION

KENT D. ENGLE
CIRCUIT JUDGE – FAMILY DIVISION

PAUL F. KRAUS
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. COVINGTON
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 45 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 and proof of payment. **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) _____
Proof of payment for each expense _____

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

FAMILY JUSTICE CENTER
12240 FILLMORE ST STE 150
WEST OLIVE MI 49460

Website: www.miottawa.org
Phone: 877-543-2660
Fax: 616-846-8128

OTTAWA COUNTY COURTHOUSE
414 WASHINGTON AVE STE 225
GRAND HAVEN MI 49417

# AFFIDAVIT OF ORDINARY MEDICAL EXPENSES

_____
Name

_____
Case Number

I, _____, declare that health care expenses incurred on behalf of the minor child(ren) have exceeded $_____which is the amount designated as the "ordinary medical expense" in my support order.

OR

I,_____, declare that health care expenses incurred on behalf of the minor child(ren) have NOT exceeded $ _____
Which is the amount designated as the "ordinary medical expense" in my support order. I request that the ordinary medical amount of $_____be deducted from the total bill before determining the amounts due by each party.

_____ Date_____
Signature

COUPON NO._____OF_____ DEMAND FOR MEDICAL

| Child Receiving Service | Physician | Date of Service | Reason for Visit | Total Cost | Amount Paid By Insurance | Balance Due * |
|---|---|---|---|---|---|---|
| | | | | | | |

REMINDER: You must fill out one coupon per bill and attach the following:

1) Attach bill for this claim
2) Attach Proof of payment in full (check, payment receipt from provider)
3) If the bill is for orthodontics, attach a copy of the contract and payment record.

*** THE BALANCE DUE IS THE TOTAL COST MINUS THE AMOUNT PAID BY INSURANCE. IF THE BALANCE DUE AMOUNT IS NOT PAID IN FULL, OUR OFFICE CANNOT ENFORCE AND YOUR BILL WILL BE RETURNED TO YOU (with the exception of orthodontics).**

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COUPON NO._____OF_____ DEMAND FOR MEDICAL

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# REIMBURSEMENT OF UNINSURED MEDICAL EXPENSES
Frequently asked questions

**What is the Ordinary Medical Expense (OME)?**
Your child support order may contain language pertaining to "ordinary medical expenses" (OME). OME are uninsured health care expenses incurred by your child up to $454 per child per calendar year. Note: older orders may indicate a different amount. Ordinary medical expenses are to be paid by the payee of support.

**What is the Ordinary Medical Amount (OMA)?**
The payee is responsible to pay a dollar amount of uninsured medical expenses each year before the other party must start paying a percentage of subsequent bills. This dollar amount is called the "ordinary medical amount" or OMA. The OMA is calculated per child. If you have more than one child, you must exceed the total amount allocated for the number of children covered in the order to have met your OMA. The OMA renews each January as it is charged in a calendar year. The OMA charge will be pro-rated as necessary.

**Why is the Payee responsible for the ordinary medical amount?**
The payer has already been ordered to contribute "medical support" as part of the child support obligation. This medical support charge represents the payer's contribution toward ordinary medical expenses.

**My child receives Medicaid and the payer's medical support is directed to the State of Michigan.**
Typically, Medicaid covers most expenses; however, if it does not, and the payee does not receive the medical support, the Friend of the Court will determine the payee's OMA based on the OMA in the order and the payee's percentage of uninsured medical expenses. Example: OMA is $403.00, payee's percentage of uninsured medical is 50%, payee must pay an OMA of $201.50 before the payer is required to contribute to uninsured expenses.

**Insurance didn't cover all of my child's medical bills. Is the other party required to help me pay for them?**
Most Orders require the parties to share a percentage of any uninsured medical expenses after one party has paid the yearly ordinary medical amount. Refer to your Support Order, to determine what percentage of uninsured medical expenses each party is responsible for.

**I've paid my ordinary medical amount for the year; how do I get reimbursed for subsequent bills this year?**
The other party is entitled to a copy of the bill, and proof that you paid it. He or she is also entitled to proof that you have met your ordinary medical amount for the year. Contact the other party directly; prepare a dated letter outlining the total amount you paid as well as the percentage due to you by the other party. Keep copies of the letter as well as bills and receipts.

**The other party will not pay his or her share of medical bills.**
If, after 45 days, the other party has not reimbursed you or has not made satisfactory arrangements to reimburse you, you may request the assistance of the Friend of the Court.

**What does the Friend of the Court need in order to assist me?**
Fill out the Demand for Health Care coupon. It is available online at www.miottawa.org/foc. You must provide the FOC with a copy of each bill, proof you paid each bill **in full**, a signed affidavit indicating that you have paid your ordinary medical amount for the year and a copy of the letter you sent to the other party requesting reimbursement.

**I cannot afford to pay the bill in full, what should I do?**
Typically, we request that you pay the bill in full before we seek *reimbursement*. In some cases, such as orthodontic treatment, the bill is large, and a contract is entered into. If you have an orthodontic contract to make monthly payments on orthodontia, the Friend of the Court will assist you. You must provide a copy of the contract.

**How does the Friend of the Court seek reimbursement of medical bills?**

The Friend of the Court will review your Support Order to determine whether the ordinary medical amount has been paid, what the percentages are and what is owed to you by the other party. If all the information (bills, receipts, affidavit, contract) is provided, an order is then prepared, requiring the other party to reimburse you through the Friend of the Court. With the exception of contracts, the monthly amount of reimbursement will be 2% of the total bill or ½ of the support obligation whichever is greater, but no less than $50.00 per month. Reimbursement for orthodontia will be ordered at the payment rate outlined in the contract. Either party has 21 days to object to the order. If an objection is made, a hearing is held before a Referee.

**I am the payor of support and medical support; will the Friend of the Court assist me in seeking reimbursement of medical bills I have paid for?**

Yes. If you have paid a bill in full and the other party is ordered to pay the OMA and or a percentage of the bill, we will assist you.

**The Friend of the Court will not enforce medical bills over a year old. How do I seek reimbursement?**

The Friend of the Court will seek reimbursement of medical bills that are no older than a year. This does not prevent you from petitioning the Court for reimbursement of older bills. If you need assistance with filing a petition, you may contact the Legal Self-Help Center.