

REIMBURSEMENT OF UNINSURED HEALTHCARE EXPENSES INFORMATION SHEET

1. Normally, the custodial parent is initially responsible to the healthcare provider for payment of the entire uninsured (out-of-pocket) portion of the healthcare bill (orthodontics would be an exception). The custodial parent should make any necessary arrangements to prevent any unpaid accounts from going into collection. After the custodial parent has paid the provider, he/she should contact the other party in writing (using the attached form) for reimbursement for that party's percentage of the bill, within one month of the bill being paid. **Please refer to your most recent Order which addresses the parties' apportioned percentages for out-of-pocket healthcare costs.** (You can obtain a copy of your Court Orders in the Clerk's Office, which is located in the basement of the Courthouse for a fee.) These percentages do not apply to ordinary expenditures for healthcare, such as nonprescription medications, vitamins, bandages, etc., which are used on a routine basis in anticipation of minor illnesses and injuries. Also, please note that the custodial parent may be required to incur, and pay a certain dollar amount of the healthcare costs for the minor children before the percentages kick in (under the new guidelines, this is \$357.00 per child, per calendar year). **However, the controlling Order applies and you must refer to the Order in effect regarding out-of-pocket healthcare costs. REIMBURSEMENT REQUESTS CAN ONLY GO BACK 1 YEAR AFTER THE EXPENSE WAS INCURRED.**
2. If there are deductibles or co-payments that are not covered by insurance and that pertain to healthcare services provided to the children, then these are considered uninsured healthcare costs for which one may seek the appropriate reimbursement. Healthcare insurance premiums are not uninsured healthcare expenses and they are NOT reimbursable, unless there is a specific Order allowing reimbursement.
3. If you are joint physical custodians, the person entitled to child support is responsible for paying the uninsured healthcare costs.
4. If you and the other party have joint legal custody of the minor children, you must consult with the other party regarding any major decision on healthcare services for the minor children. A decision to proceed with an elective healthcare procedure (example: orthodontics-braces) is normally interpreted to be a major decision, requiring involvement by both legal custodians.
5. In cases with multiple children on the same case, the total uninsured medical amount must be paid by the custodial parent/payee before reimbursement is permitted. For example, for three children, the uninsured medical obligation is \$357.00 per child, per year, or \$1072.00 for all three children for the year. Once the custodial parent/payee has paid a total of \$1072.00 out of pocket (not \$357.00 per child), any out of pocket expenses beyond the \$1072.00 can be considered for reimbursement. In other words, one child with major medical expenses could satisfy the entire \$1072.00 yearly amount. If this happens, the second child with out of pocket costs of \$100.00 could be submitted for reimbursement since \$1072.00 has already been paid.

6. The uninsured medical amounts pursuant to the child support guideline are:

	<u>Current Guideline</u>	<u>Previous Guideline</u>
1-Child	\$357.00	\$345.00
2-Children	\$715.00	\$690.00
3-Children	\$1072.00	\$1034.00
4-Children	\$1430.00	\$1379.00
5+Children	\$1787.00	\$1724.00

7. If you are the party requesting assistance in the enforcement of a Court Order concerning healthcare expenses, you must cooperate and appear at any Friend of the Court appointment/hearing if one is scheduled. Your failure to do so will result in the Friend of the Court ceasing to assist you and/or denying your request.
8. If you are the party being asked to reimburse for uninsured healthcare expenses, you must cooperate and appear at any Friend of the Court appointment/hearing if one is scheduled. Your failure to do so may result in granting the requesting party his/her relief.
9. Either party may be assessed Court costs/fees for failure to cooperate.

REIMBURSEMENT OF UNINSURED HEALTHCARE EXPENSES PROCEDURE

- A. Before requesting assistance from the Friend of the Court Office, the party requesting reimbursement must attempt to cooperatively resolve the reimbursement issues with the other party as follows:
1. After payment in full for healthcare services rendered, including payment by the insurance company of its share, contact the other party in writing, (using the attached forms), requesting reimbursement of his/her share of the expense, within one month of the bill being paid. You must include all the information on the form. You must include copies of documents showing proof of all of the information you put on the form. Statements of accounts from healthcare provider, cash receipts, cancelled checks, documents from the insurance company, etc. **Your written request to the other party should also indicate that he/she is being allowed 30 days to pay the reimbursement.**
 2. If your support Order includes the amount for ordinary healthcare costs, then your Order was entered consistent with the new guidelines and prior to seeking reimbursement, you must incur and pay **\$357.00** per child each calendar year prior to requesting reimbursement. Therefore, you must show proof in your written request to the other party that you have paid these amounts of monies.
 3. Retain a copy of your written request for reimbursement with all attachments for further use if the matter is not resolved at this stage as you will need to submit the your request and all attachments to the Friend of the Court with your request for assistance.
- B. If you are unable to resolve the reimbursement issues with the other party, then you may notify the Friend of the Court in writing that further assistance is needed. This can only be done after you have paid a minimum of \$250.00 per child in uninsured healthcare expenses OR if the bills are near a year old you can submit for under the \$250.00. Please use attached form, "Request for Friend of the Court Assistance". You may request assistance from the Friend of the Court Office no more than two times per calendar year.
- C. The Enforcement Officer will review the information and make a determination as to whether or not she will prepare an Order with a Notice of Presentment for the Court. However, if one party is found at fault that party may be assessed Court costs/fees. Either party may file an Objection to the Proposed Order and schedule a Hearing with the Court in accordance with the Court rules.

**REQUEST FOR FRIEND OF THE COURT ASSISTANCE REGARDING
UNINSURED HEALTHCARE EXPENSES**

I request the Friend of the Court Office enforce healthcare expenses, I declare that:

- a. I am submitting this request pursuant to my most recent Court Order dated:_____.
- b. This is either the first or second request in this calendar year and I realize that a request cannot be made more than two times in each calendar year; the total amount in question that I have paid is not less than \$250.00 OR the bills are near a year old.
- c. The amount which the other party owes me in reimbursed healthcare costs for the healthcare services rendered to the minor children as of this date is \$_____.
- d. I have mailed a copy of this request to the other party and have attached a copy of my initial request to the other party for the Friend of the Court.
- e. I have attached a copy of my reimbursement request to the other party along with all necessary **supporting documentation**. (Failure to provide the documents will result in a delay in the settlement of this matter.)
- f. I have made a written request to the other party for reimbursement of healthcare costs, within one month of the bill being paid by me and the opposing party has failed to cooperate by refusing to pay his/her port of the out-of-pocket healthcare costs.

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

I hereby request Child Support Services under the Child Support Enforcement Program of Title IV-D.

Date: _____

Signature

Printed Name

Case # _____

Phone Number

REQUEST FOR REIMBURSEMENT OF PAID HEALTHCARE EXPENSES

(Use one form **per child** - make copies as needed)

1. Name of parties: _____
2. Case #: _____
3. Name of child _____
4. Total amount of bill(s): _____
5. Total amount Insurance paid: \$ _____
6. Amount I Paid: _____ Date Paid: _____
7. Reimbursement Amount: _____
8. Do you have an HSA (Health Savings Account)? Yes No
9. If you answered yes to # 8 above:
 - a. Employer's contribution per month: _____
 - b. Employee's contribution per month: _____
 - c. Number of individuals covered on the HSA (including child(ren) on this case): _____

PLEASE ATTACH DOCUMENTATION REGARDING HSA ACCOUNT IF APPLICABLE

THE ABOVE INFORMATION IS A TOTAL OF THE INFORMATION ON PAGE 5 WHICH IS ATTACHED.

I have attached copies of all documents showing proof of the above (statements of accounts from healthcare providers, cash receipts, cancelled checks, documents from the insurance company, etc.)

I am requesting that you pay your portion to me no later than: _____ in order to avoid having the Friend of the Court involved. If payment is not received by that date I will request the Friend of the Court to enforce the Reimbursement provision of our Court Order.

Date

Signature/ Custodial Parent

Phone Number

CHILD RECEIVING SERVICE/ TYPE OF SERVICE	NAME OF PROVIDER (PHYSICIAN OR DENTIST)	DATE OF SERVICE	DATE OF PAYMENT OF UNINSURED AMOUNT	TOTAL AMOUNT OF BILL	AMOUNT PAID BY INSURANCE (INSURED AMOUNT)	AMOUNT PAID BY CUSTODIAN (UNINSURED AMOUNT)	OUTSTANDING BALANCE (SHOULD BE \$0 EXCEPT FOR ORTHO)

****** YOU MAY PHOTOCOPY THIS PAGE AS MANY TIMES AS NEEDED******

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

Date

Signature of Party Submitting Request
(01/2013)