

EDWARD R. POST
CHIEF CIRCUIT JUDGE – TRIAL DIVISION

CALVIN L. BOSMAN
CIRCUIT JUDGE – TRIAL DIVISION

JON HULSING
CIRCUIT JUDGE – FAMILY DIVISION

JON A. VAN ALLSBURG
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

JENNEL L. CHALLA
FRIEND OF THE COURT

THOMAS H. MILLER
ASSISTANT FRIEND OF THE COURT

SHERRY VANBEMMELEN
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 28 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. **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) _____

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

Ottawa County Friend of the Court
414 Washington Ave – Suite 225
Grand Haven, MI 49417

DEMAND FOR HEALTH CARE PAYMENT

(expenses other than orthodontic)

Other Party's Name _____

Case # _____

Address _____

City, State, Zip _____

LIST EACH EXPENSE SEPARATELY
IF YOU HAVE ORTHODONTIC EXPENSES COMPLETE FORM ON BACK

Child receiving service	Physician	Date of service	Reason for visit	Total cost by insurance	Amount paid	Balance due

I declare that the above statements are true to the best of my information, knowledge, and belief and that I mailed a copy of these expenses by ordinary mail to the other party at their last known address.

Date

Signature

The above expenses have been submitted to the Friend of the Court for enforcement. To avoid further court action these expenses must be paid within 28 days. You must provide our office with proof of your payment to receive proper credit.

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

Total medical cost not paid by insurance: \$ _____

Percentage owed by payer: x _____%

Total amount due: \$ _____

Date of mailing by court:

DEMAND FOR HEALTH CARE PAYMENT - ORTHODONTICS ONLY!!

Other Party's Name

Case # _____

Address

City, State, Zip

For enforcement of orthodontic expenses you must include the following:

A copy of the orthodontic contract

An account summary showing all payments

Child receiving service	orthodontist	date contract began	total cost	amount paid by insurance	amount paid/ balance

I declare that the above statements are true to the best of my information, knowledge, and belief and that I mailed a copy of these expenses by ordinary mail to the other party at their last known address.

Date

Signature

The above orthodontic expenses have been submitted to the Friend of the Court for enforcement. This notice is a demand for payment. Please contact the other party or the orthodontist and arrange for payment of these expenses within **14 days**.

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

Total cost of orthodontics: \$ _____

Monthly payment amount: \$ _____

Percentage owed by payer: _____%

Total amount owed by payer: \$ _____

Date of mailing by court

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AFFIDAVIT OF EXPENSES

Name

Case number

I _____ declare that health care expenses
(Print your name here)

incurred on behalf of the minor child(ren) have exceeded \$_____ which is the amount designated as “ordinary medical expenses”. I have presented copies of these expenses to the other party.

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

Date

Signature

LIST THE EXPENSES ON THE BACK OF THIS PAGE.
(List expenses applied to ordinary medical allotment)

This form is to be used only if your order allows for “ordinary medical expenses”

Name	Date of expense	Reason for visit	Total	Balance due

Grand total _____