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DOMESTIC RELATIONS SECTION
THIRTY-EIGHTH JUDICIAL DISTRICT
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UNREIMBURSED BILLS INSTRUCTION SHEET

1. This form is only applicable for unreimbursed medical/dental expenses, and if educational, daycare, summer camp, psychological, home equity and/or mortgage expenses are a special condition of your **CURRENT COURT ORDER**. If they are NOT, you must file a Petition to Modify form in addition to this form.

2. The **Petitioner** (***the party seeking reimbursement***) should send copies of outstanding bills, proof of insurance payments, and applicable co-payments to the **Respondent** (***the party who owes the reimbursement***) by Certified Mail return receipt requested (Green Signature Card). You must allow the Respondent **30 days to pay** or to make arrangements to pay either the provider or you, the Petitioner, before submitting your request for a Medical Support and/or Special Conditions Contempt conference.

WE WILL NOT SCHEDULE A CONFERENCE WITHOUT PROOF OF SERVICE AND PROOF OF PAYMENTS (RECEIPTS) FOR WHICH YOU ARE SEEKING REIMBURSEMENT.

3. If no arrangements or payments have been made, complete the attached summary sheet(s) (one sheet per /person that you are seeking a reimbursement) and staple it to the copies of all paid bills and receipts. **You MUST use our summary sheet(s) to submit a request**.

4. **Our office needs *all of the following items* when preparing your case for a Medical/ Special Conditions Contempt Conference:**

****** Copies may not be emailed or faxed ******

Packets must either be submitted by USPS 1st Class Mail or hand delivered to the Front Desk at Domestic Relations

- (3) Copies of the completed Summary Sheet(s)
- (3) Copies of the **provider's bill(s) and receipt(s)* at the time of service**.
(***No statements in lieu of receipts, please***)
*Receipts must clearly state the provider's name, address & phone number.
- (3) Copies of your payment or co-payment to the provider.
- ***Proof of Certified Mail service to the Respondent***. You can obtain a receipt for this at the Post Office (e.g. signed green card or electronic forms may be acceptable). (Note: If the Respondent has an attorney of record then, certified mail service may be sent to the attorney's address on behalf of the Respondent). ***We cannot schedule a conference without proof of service to the Respondent***.

5. **Requests must be made in a complete, organized manner**. Incomplete, hard to read summary sheets and/or receipts will be returned to you.

6. **If you are the Plaintiff on this case** and the court order requires you to pay the first $250.00 per/person, per/ year before the Defendant's obligation begins, you **MUST** submit receipt(s) proving this deductible has been met.

7. **If you are the Defendant on this case**, you **MAY** be reimbursed at 100% up to the first $250.00 per/person, per/year for which you have submitted expenses. (Note: If you submit only $150 in qualified reimbursable expenses, then your maximum reimbursement shall not exceed $150.00). Any expenses in excess of $250.00 per/ person, per/year will be shared by both parties as allocated by your applicable court order.

8. If your provider bill(s) and receipt(s) include **out-of-network expenses**, the party seeking reimbursement **MAY** be held liable at 100% for those expenses that exceed the applicable co-pay had an in-network provider been used for this service.

9. Documentation of un-reimbursed medical expenses that either party seeks to have allocated shall be provided to the other party ***not later than March 31*** of the year following the calendar year in which the final bill was received by the party seeking allocation.

Please follow all instructions to avoid a delay in the scheduling of a Conference.

Complete if you are a PLAINTIFF seeking
MEDICAL EXPENSE REIMBURSEMENT

Date of Service	Medical / Dental or Pharmacy Provider	Patient's Name (1 person per/page)	Total Amount of Bill	Amount Paid by Insurance	Insurance Co-payment	Amount Owed by Defendant
TOTALS						

*** * * * * PLEASE LIST ALL RECEIPTS BY DATE ORDER * * * * ***

Complete if you are a PLAINTIFF seeking
CHILD CARE EXPENSE REIMBURSEMENT

Date of Service	Child Care / Summer Camp Provider	Child's Name	Total Amount of Bill	Is there a subsidy or scholarship?	Amount Paid by Plaintiff	Amount Owed by Defendant
TOTALS						

*** * * * * PLEASE LIST ALL RECEIPTS BY DATE ORDER * * * * ***

Complete if you are a PLAINTIFF seeking
TUITION EXPENSE REIMBURSEMENT

Tuition Year / Semester	School Name	Student's Name	Total Amount of Bill	Is there a subsidy or scholarship?	Amount Paid by Plaintiff	Amount Owed by Defendant
TOTALS						

* * * * * **PLEASE LIST ALL RECEIPTS BY DATE ORDER** * * * * *