STATE OF MICHIGAN 45TH JUDICIAL CIRCUIT ST. JOSEPH COUNTY	**DEMAND FOR** **MEDICAL PAYMENT**	CASE NUMBER

Friend of the Court PO Box 249, Centreville MI 49032 (269)467-5570

Plaintiff's Name and Address:

_____

_____

_____

Defendant's Name and Address:

_____

_____

_____

The following expenses are being submitted to the Friend of the Court for enforcement. I have already submitted these expenses for any available insurance payments. Attached are supporting bills and receipts for all expenses listed, explanation of benefits, and a letter to the other party seeking payment.

Child	Physician/ Hospital	Date	Nature of Service	Total Cost	Amount Paid By Insurance	Amount paid By Me	Balance Due
			TOTAL				

_____ _____

Date Signature of Requesting Party

Unless you file a written objection with the Friend of the Court within 21 days, the amount listed below becomes a support arrearage subject to enforcement.

Do Not Write Below This Line - For Friend of the Court Use Only

Total medical cost not paid by insurance $_____

Annual ordinary health care amount $_____

Amount to be divided between parties $_____

Percent to be paid by Plaintiff/Defendant _____%

Total Amount Due:

Plaintiff/Defendant and Provider $_____

_____ _____

Date of Mailing by Court Medical Support Enforcement Clerk