STATEMENT OF HEALTH CARE EXPENSES

Name of Parent Filling Out Statement _____ ☐ Parent A ☐ Parent B

In the chart below, list each health care expense, beginning with the oldest one. If you do not know the answer to a question, write "unknown" in that box.

Attach: (1) a copy of each health care provider's bill,
(2) proof of any amount you paid the provider,
(3) a copy of each "Explanation of Benefits" (EOB) from an insurance company, and
(4) a copy of each request for payment you sent the other parent.

At the bottom of each attached document, write and circle the number on the chart that corresponds to that item. Attach the documents in order by that number.

	a Date of health care service	b Name of health care provider	c Name of Patient	d Amount charged by provider (attach copy of bill)	e Amount you paid provider (attach proof of payment)	f Amount paid by insurance companies (attach EOBs)	g Amount not paid by any insurance company and still owed on bill	h Amount other parent owes you	**FOR COURT USE ONLY** Court Findings i Amount owed	 j Owed to
1										
2										
3										
4										
5										
6										
7										
							Total	0		