MEDICAL EXPENSE SUBMISSION FORM

Name of person receiving medical services _____ (one person per worksheet)

Attach copies of bills for all expenses listed

Date of Service	Medical Provider	Total Expense	Paid by insurance	Balance Due
	TOTALS			**$**

- **250**

Outstanding Medical Expense Balance = [ ]

The respondent is ordered to pay ____**%** of medical expenses

Multiply the respondent _____**%** by the **$**_____ Outstanding Medical Expense Balance

Amount respondent owes = [ ]

1.2017