**HEALTH CARE EXPENSE WORKSHEET**

|  |  |
| --- | --- |
| **CHILD’S NAME:** |  |

|  |  |  |
| --- | --- | --- |
| **DATE OF SERVICE:** |  |  |
| **NAME OF PROVIDER:** |  |  |
| **WHAT EXPENSE WAS FOR :** |  |  |
| **ORIGINAL TOTAL CHARGE BY PROVIDER:** |   | $ |
| **AMOUNT INSURANCE PAID:** | - | $ |
| **UNINSURED AMOUNT:** | =  | $ |

|  |  |  |
| --- | --- | --- |
| **EACH PARENTS PERCENTAGE OF UNINSURED HEALTH CARE EXPENSES UNDER COURT ORDER** | Name:\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ % | Name:\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_% |
| **EACH PARENTS PORTION OF TOTAL UNINSURED BILL** (multiply the amount in the gray box above by each parents percentage) |  **$** |  **$** |
| **SUBTRACT any amounts already paid to the health care provider by each parent ON THIS BILL** | **- $** | **- $** |
| **AMOUNT EACH PARENT OWES TO THE PROVIDER AND/OR TO THE OTHER PARENT AS REIMBURSEMENT** (if the number is negative, then that parent is owed money by the other parent) | **= $** | **=$** |

|  |  |
| --- | --- |
| Prepared by:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Provided to other parent on: |  | How Provided: |  |

**\*\*\*COPIES OF THE HEALTH CARE BILL AND ANY EXPLANATION OF BENEFITS FROM THE INSURANCE COMPANY MUST BE ATTACHED\*\*\***