Below is the Medical Form that must be completed to seek enforcement for reimbursement. Please complete the form entirely and understand that the medical expenses must be paid in full to seek reimbursement, except for Orthodontia expenses. Follow **Step 1** of the reimbursement procedure prior to **March 31**st of the following calendar year. If you are not reimbursed for your medical expenses in a timely manner, return the completed form to the Domestic Relations Section as specified in **Step 2** of the reimbursement procedure. Along with this form, you will need to provide copies of the medical bills from the providing facility or physician (showing payment in full, dates of service, and party receiving service) - Explanations of Benefits (EOBs) are not accepted in place of the medical bills - and proof of service (certified mail receipt). *Please also provide your insurance coverage summary information; include co-pays, co-insurance, deductible amounts, along with if service is in-network.*

NOTE: PSYCHIATRIC, PSYCHOLOGICAL, CHIROPRACTIC AND COSMETIC SERVICES **ARE NOT** INCLUDED IN THE UNREIMBURSED MEDICAL PROVISIONS UNLESS SPECIFICALLY DIRECTED IN YOUR ORDER OF COURT.

Please remember, if your Order of Court requires you to pay the first $250.00 per child/spouse per year, this amount will be deducted from the total of the submitted expenses prior to the proportional shares. If you have any questions, please contact our office. Thank you.

If Requesting Reimbursement of Orthodontia expenses, you will need to provide a letter stating it is medically necessary, along with the contract, the payment plan with proof of any payments made, and any insurance payments.

DOCKET NO. ______________________________ PACSES NO. ____________________________________

PLAINTIFF ________________________________ DEFENDANT ___________________________________

Name of Dependent ____________________ $250.00 paid (if applicable) ______________ Proportional Share: (P) ______ (D) ______

Co-Pay __________ Deductible ___________ Co-Insurance (percentages or amounts) __________________________________

A separate form must be completed for each person for which reimbursement is being sought

	Date of Service	Name of Doctor, Service Provider, Or Medical Facility	Amount of Bill	Amount Paid by Insurance	Amount Paid	
Example:	1/5/04	Butler Memorial Hospital	$500.00	$375.00	$125.00	Total amount Paid:
						Less Annual $250.00
						=
						Multiplied by the Proportional share: %
						Total Due:

Updated 6/2023

BUTLER COUNTY DOMESTIC RELATIONS MEDICAL REIMBURSEMENT PROCEDURES

THE TERM UNREIMBURSED MEDICAL EXPENSES REFERS TO THE MEDICAL EXPENSES THAT ARE INCURRED ON BEHALF OF THE PARTY (child/ spouse) COVERED BY THE ORDER OF COURT AND ARE **NOT** PAID BY THE INSURANCE COMPANY AND THUS ARE PAID FOR 'OUT OF POCKET' BY THE PARTY SEEKING THE REIMBURSEMENT.

BEFORE SEEKING THIS REIMBURSEMENT, ALL MEDICAL EXPENSES **MUST** BE PAID IN FULL (exception: Orthodontia)

THE UNREIMBURSED MEDICAL EXPENSES MUST BE SUBMITTED TO THE RESPONSIBLE PARTY BY CERTIFIED MAIL AND THE RESPONSIBLE PARTY MUST BE GIVEN THIRTY (30) DAYS TO REIMBURSE THE PARTY THAT SUBMITTED THE EXPENSES

THE FOLLOWING REIMBURSEMENT PROCEDURE MUST BE FOLLOWED IN ORDER FOR THE DOMESTIC RELATIONS SECTION TO ENFORCE FOR PAYMENT.

STEP 1

- A Medical Insurance Verification form (inside) must be completed for EACH member that has unreimbursed medical expenses. Please refer to the most current Court Order to determine if the plaintiff is responsible for the first $250.00 per calendar year per child and/or spouse. If so, this amount will be deducted from the total of the submitted expenses.
- The completed form and copies of all medical expenses (statements from the facility/physician) and receipts (proof of payment in full) showing dates of service, what service was received, and the person for whom service was rendered must be sent to the other party by **Certified Mail, Restricted Delivery, no later than March 31st of the following calendar year**.
- The party must be given thirty (30) days to pay the bills in full before enforcement may be sought.
- Should the other party not respond with payment, please follow STEP 2.

STEP 2

- It is the responsibility of the person submitting this form to have ALL information correct and amounts totaled. If it is not presented in this format, it will be returned to you without processing.
- Provide COPIES of medical expenses and documentation along with the proof of service to the other party (certified mail receipt), which verifies you notified the other party of the incurred expenses, to the Domestic Relations.
- Refer to your Court Order to determine if the plaintiff is required to pay the first $250.00, this amount will be deducted from the total of the submitted expenses if applicable.

Updated 6/2023

The Domestic Relations Section reserves the right to determine the length of time the Defendant will be given to pay the unreimbursed medical expenses.

If Orthodontia needs addressed, the party must provide documentation that the procedure is medically necessary, along with the contract, payment plan, any payments made by the party, and any payments made by the insurance company.

The party seeking allocation of the unreimbursed medical expenses (the out of pocket expenses not paid by the insurance company) must follow these procedures and provide documentation of expenses to the other party no later than March 31st of the year following the calendar year in which the final medical bill to be allocated was received.

If the party responsible for reimbursement fails to pay, this matter will be scheduled for a contempt conference. At the time of the conference, you must be able to provide proof of having complied with the instructions cited above.

Butler County Domestic Relations

www.butlercountypa.gov/drs

Medical Reimbursement Procedures and Verification Form

PO Box 1208

Butler, PA 16003-1208

Tel: 724-284-5181

Fax: 724-284-5422