MEDINA COUNTY DOMESTIC RELATIONS COURT
EXPLANATION OF MEDICAL EXPENSES

DATE OF TREATMENT	NAME OF SERVICE PROVIDER (E.G., DOCTOR, DENTIST, HOSPITAL)	TOTAL BILL	AMOUNT INSURANCE PAID	AMOUNT YOU PAID	AMOUNT OTHER PARENT PAID	AMOUNT UNPAID	AMOUNT DUE FROM OTHER PARENT	DATE EOB OR BILL PROVIDED TO OTHER PARENT
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	
		$	$	$	$	$	$	

TOTAL AMOUNT CLAIMED: $ _____

_____ _____

Signature Date

Instructions: This form is used to track the (non-)payment unreimbursed medical expenses. **Use a separate form for each child.**

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