Uninsured Expense Reimbursement Form

To: _____ (Name of person who owes reimbursement)

Mailing Address: _____

From: _____ (Name of person making claim)

Mailing Address: _____

Date Mailed: _____ Date Due from other party: _____

Total Due from the Other Party $_____ (based on ____% reimbursement obligation)

Date of Service	Provider/Purpose	Medical	Prescriptions	Dental/Ortho	Vision
	TOTALS >>	**$**	**$**	**$**	**$**

Suggested Instructions:

1. **Fill in all blanks including date of service, name of provider (i.e. doctor, dentist, etc.), the purpose (i.e. eyeglasses, illness, cleaning, etc.).**
2. **Fill in amount paid out of pocket (not reimbursed by any employer or insurance company).**
3. **If possible, submit form to other parent on a monthly basis with copies of billings.**
4. **Keep a copy of everything and note date mailed.**
5. **Keep copies of checks or credit card statements showing personal payment.**
6. **Make reimbursement to other party as per court order/judgment.**
7. **Use additional pages if necessary. This form is intended to simplify the sharing of information when making claims for uninsured reimbursement.**