

MEDICAL ENFORCEMENT REQUEST FOR CREDIT – Unreimbursed Medical Expenses Paid by Defendant

PACSES CASE ID. # _____

Plaintiff

DEPENDENT NAME: _____

CALENDAR YEAR: _____

Defendant

DATE OF SERVICE	TYPE OF SERVICE	TOTAL BILL (attach copy for each)	AMOUNT PAID BY INSURANCE (attach copy for each)	BALANCE PAID BY DEFENDANT AFTER INSURANCE	DATE PLAINTIFF NOTIFIED	AMOUNT PAID BY PLAINTIFF
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Return completed form with attachments to:
Lancaster County Domestic Relations
PO Box 83479 Lancaster PA 17608-3479

AMOUNT TO BE SPLIT
BASED ON ORDER: PLAINTIFF'S % SHARE
PLAINTIFF'S TOTAL AMOUNT OWED
MINUS PAYMENTS MADE BY PLA
AMOUNT REQUESTED BY DEF

TOTAL \$
=
X %
=
-
=

*The recipient of support will be responsible to pay the first \$250.00 of any uncovered medical expenses for each dependent covered by the support order in each calendar year.

I, _____, verify that the facts set forth above and all attachments thereto are true and correct to the best of my knowledge, information, and belief. I understand that any false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

DEFENDANT CONTACT INFORMATION:
Daytime Phone #:
Email Address:

Defendant Signature

Date