

## MEDICAL ENFORCEMENT REQUEST FORM – Unreimbursed Expenses Paid by Plaintiff

PACSES CASE ID. # \_\_\_\_\_

\_\_\_\_\_  
Plaintiff

DEPENDENT NAME: \_\_\_\_\_

CALENDAR YEAR: \_\_\_\_\_

\_\_\_\_\_  
Defendant

| #  | DATE OF SERVICE | TYPE OF SERVICE | TOTAL BILL<br>(attach copy for each) | AMOUNT PAID BY INSURANCE<br>(attach copy for each) | BALANCE DUE AFTER INSURANCE | DATE DEFENDANT NOTIFIED | AMOUNT PAID BY DEFENDANT |
|----|-----------------|-----------------|--------------------------------------|--|-----------------------------|-------------------------|--------------------------|
| 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: DEFENDANT'S % SHARE  
DEFENDANT'S TOTAL AMOUNT OWED  
MINUS PAYMENTS MADE BY DEF  
AMOUNT REQUESTED FROM DEF

|                 |
|-----------------|
| <b>TOTAL \$</b> |
| -\$250.00       |
| =               |
| <b>X</b> %      |
| =               |
| -               |
| =               |

\*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.

|   |
|---|
| <b>PLAINTIFF CONTACT INFORMATION:</b><br>Daytime Phone #: _____<br>Email Address: _____ |
|---|

\_\_\_\_\_  
Plaintiff Signature

\_\_\_\_\_  
Date