The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

DATE TOTAL AMT. PAID NAME OF MEDICAL TYPE OF BALANCE OBLIGOR'S AMT. CHILD PROVIDER OF SERVICE MEDICAL BYDUE* PERCENT OWED SERVICE COST **INSURANCE** ΒY OBLIGOR

HEALTH CARE EXPENSE LOG

I declare that the above statements are true to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expense Payment to the obligor at his or her last known address.

Date

Signature

*Balance due means balance owed after payment by insurance and any adjustments to the total medical cost.