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

HEALTH CARE EXPENSE LOG

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

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.