Child Support Program

Worksheet for Medical Expenses Not Covered by Insurance

CS-EF206
Rule 12E-1.031
Florida Administrative Code
Effective 04/05/16

Child Support Case Number: <CSE case number>

Depository Number: <<DepositoryNumber>>

Other Parent: <<NCP first name, middle initial, last name, suffix>>

Activity Number: <<ActivityNum>>

INSTRUCTIONS - Please read this page before completing the worksheet.

Step 1: Fill in all the information on the worksheet.

Step 2: Attach proof of your expenses and payments. The proof must show:

1. The name of the doctor or medical provider
2. The date the service was provided
3. The bill, statement, or proof of payment must include the name of the child(ren)
4. The total amount of the medical expenses
5. The amount of the medical expenses that **you** paid

Number each document you attach with the item number from column 1 on the worksheet. For example, if you paid a doctor bill and recorded that expense on line 3 of column 1, write a “3” (and circle it) on both the bill and your canceled check or other proof of payment.

Step 3: Fill in the total number of items entered on the worksheet. If more than one page is used enter the total for all pages.

Step 4: Fill in the total amount to be paid by the other parent.

Step 5: Attach a copy of all receipts, invoices, insurance statements, bills, or proof of payment to the worksheet.

Step 6: Print your name, sign and date the worksheet.

Step 7: Return the forms and proof of medical expenses and payment to:

Child Support Program
<<Insert Street Address of local service site>>
<<Insert City, State and Zip of local service site>>

To contact us call **<<Option 1>>**.

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Other Parent: <<NCP first name, middle initial, last name, suffix>>

Depository Number: <<Depository Number>>
Activity Number: <<ActivityNum>>

Step 1: For each expense you paid, provide the information below (please copy form and attach more pages if needed).

Column 1 Item Number	Column 2 Date of Service	Column 3 Name of Minor Child	Column 4 Amount of Medical Expense	Column 5 Amount You Paid	Column 6 Amount Paid by Other Parent	Column 7 Amount Owed by Other Parent
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
					TOTAL =	

Step 2: **Total number of items provided**_____ **(the total number of items listed in column 1 <u>on all pages</u>)**

Step 3: **Total amount requested to be paid by the Other Parent** _____ **(the total of column 7 <u>for all pages</u>)**

Step 4: Attach a copy of all receipts, invoices, insurance statements, bills, or proof of payment to the worksheet.

Pursuant to section 92.525, Florida Statutes, under penalties of perjury, I declare that I have read this statement and that the facts stated in it are true.

_____ _____ _____

Step 5: Your name (print) Signature Date

Option 1 (based on the office handling the case)

A. 1-305-530-2600 **(if case is handled in Miami-Dade County)**

B. 1-800-622-KIDS (5437) **(all other sites)**