Child Support Program

**Information Request for
Repayment of Medical Expenses**

If your address has changed, provide new address here

<<date>>
Child Support Case Number:<<CSECaseNum>>
Activity Number: <<ActivityNumber>>
Other Parent: <<NCPfirst,middle,lastNamesuffix>>

We received your request for repayment of medical expenses not covered by insurance.

We are missing information needed to act on your request.

<<Option 1>>

Return this form and the above listed items to us at the address below within 21 days from the date of this notice. We cannot proceed with your request without this form and the above checked items.

XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX
XXXX

Return this form and the above checked items to:

Child Support Program
<<LocalServiceSiteAddr>>
<<LocalServiceSiteAddr>>

To contact us **<<Option 2>>**.

Option 1 (All and any combination could appear)

A. Complete, sign and return the "Statement of Medical Expenses Not Covered by Insurance" (Form CS-EF205).
B. Complete, sign and return the "Worksheet for Medical Expenses Not Covered by Insurance" (Form CS-EF206).
C. You did not give us proof of payment for the medical expenses you are claiming. Please submit copies of the invoice, cancelled check, or credit card statement to show proof of payment.
D. You did not give us a copy of your documention that was sent to the other parent requesting them to reimburse you for their part of the medical expenses. Documentation can be a letter, email, fax, social networking page, electronic text message, etc.
E. << FreeFormText>>

Option 2 (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)**