Attachment A: UNREIMBURSED MEDICAL, DENTAL & VISION CARE EXPENSES

Case Number: _____

Father's Name: _____ **Father's share of all unreimbursed expenses listed on this sheet is:** _____

Mother's Name: _____ **Mother's share of all unreimbursed expenses listed on this sheet is:** _____

Total: **100%**

Date of Service (oldest-first)	Name of Health Care Provider	Total Amount of Bill	Amount of Bill Paid by Insurance or 3rd Party	Amount of Bill Paid by Father	Amount of Bill Paid by Mother	Remaining Balance of Bill Due	Amount of Father's Remaining Responsibility	Amount of Mother's Remaining Responsibility
Totals for This Sheet		**$**	**$**	**$**	**$**	**$**	**$**	**$**