UNREIMBURSED MEDICAL EXPENSE FORM

YEAR__________________________

PLAINTIFF_______________________ DEFENDANT_____________________ CASE #________________

DEPENDENT FOR WHOM EXPENSES INCURRED _______________________________
(only one per page)

Plaintiff's share of unreimbursed expenses ____________%
Defendant's share of unreimbursed expenses ____________%

Medical Service Date	Type of Service	Total Bill Amount	Insurance Reimbursement Amount	Total Balance	Plaintiff Paid	Defendant Paid	Defendant Balance & Payable to Whom	Date Defendant Received Bill

Plaintiff signature___________________________ **Date**__________________

EN-024