

# Uninsured Expense Reimbursement Form

To: \_\_\_\_\_ (Name of person who owes reimbursement)

Mailing Address: \_\_\_\_\_

From: \_\_\_\_\_ (Name of person making claim)

Mailing Address: \_\_\_\_\_

Date Mailed: \_\_\_\_\_ Date Due from other party: \_\_\_\_\_

Total Due from other party: \$\_\_\_\_\_ (based on \_\_\_% reimbursement obligation)

Date of Service	Provider/Purpose	Medical	Prescriptions	Dental/Ortho	Vision
<b>TOTALS &gt;&gt;</b>		<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

**Suggested Instructions:**

1. Fill in all blanks including date of service, name of provider (i.e. doctor, dentist, etc.), the purpose (i.e. eyeglasses, illness, cleaning, etc.).
2. Fill in amount paid out of pocket (not reimbursed by any employer or insurance company).
3. If possible, submit form to other parent on a monthly basis with copies of billings.
4. Keep a copy of everything and note date mailed.
5. Keep copies of checks or credit card statements showing personal payment.
6. Make reimbursement to other party as per court order/judgment.
7. Use additional pages if necessary. This form is intended to simplify the sharing of information when making claims for uninsured reimbursement.