Case No.______________________________

ATTACHMENT C: UNREIMBURSED MEDICAL, DENTAL & VISION CARE EXPENSES

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	$	$	$	$	$	$	$

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