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**_____