Minnesota Department of **Human Services**

Unreimbursed and/or Uninsured Medical/Dental Expenses Packet.
This packet is for the requesting party to collect unreimbursed and/or uninsured medical/dental expenses from the non-requesting (liable) party. This packet contains the:
- Information Notice for Collection of Unreimbursed and/or Uninsured Medical/Dental Expenses
- The Notice of Intent To Collect Unreimbursed and/or Uninsured Medical/Dental Expenses-Requesting Party
- Affidavit of Health Care Expenses
(This note will not print when printing this form.)

Information Notice for Collection of Unreimbursed and/or Uninsured Medical/Dental Expenses

Purpose

This notice tells you, the Requesting Party, the steps to take to collect unreimbursed and/or uninsured medical/dental expenses from the other party.

Definition of terms

The following terms are used in this notice:

Uninsured medical expenses

Reasonable and necessary health-related expenses incurred if the child is not covered by a health plan when the expenses are incurred.

Unreimbursed medical expenses

Reasonable and necessary health-related expenses not covered by the child's health plan, such as deductibles, co-payments, orthodontia, prescription eyeglasses and contact lenses. Unreimbursed medical expenses do not include the cost of premiums or over-the-counter medications.

Requesting payment

If your court order requires the other party to pay towards unreimbursed and/or uninsured medical/dental expenses and you want the Child Support Agency to collect the other party's share of the expense(s), you must complete the attached Affidavit of Health Care Expenses and follow the steps below:

1. Complete the attached **Affidavit of Health Care Expenses** (DHS-4931A), showing the full amounts you paid or owe to the provider. Do not include:
   - Amounts that the insurance company, or public health program (Medical Assistance or MinnesotaCare) processed
   - Amounts the medical or dental provider billed the other party directly
   - Amounts for your monthly premiums, co-pays for MinnesotaCare or any other public health program, or expenses that are not considered medical or dental expenses as defined by law
   - Amounts that are more than two (2) years old at the time of your request.

   Important: Your signature on the Affidavit of Health Care Expenses must be notarized.

2. Send the following documents to the other party to the most current address you know or to the last known address in the court file:
   - A **copy** of the Affidavit of Health Care Expenses
   - **Copies** of all bills, receipts, and the Explanation of Benefits that you received from the insurance company
   - The **original Notice of Intent to Collect Unreimbursed and/or Uninsured Medical/Dental Expenses-Requesting Party** (DHS-4931B)

   Note: Keep the originals of the bills, receipts, and the Explanation of Benefits that you received from the insurance company for your records.

   The Child Support Division recommends that requesting parties request payment towards unreimbursed and/or uninsured medical/dental expenses quarterly.

   If you have safety concerns, please contact your child support officer.

3. If the non-requesting party fails to pay the requested amount, or if the two of you cannot agree to a payment schedule within 30 days, send the following to the child support agency:
   - A **copy** of the Affidavit of Health Care Expenses
   - A **copy** of the Notice of Intent to Collect Unreimbursed and/or Uninsured Medical/Dental Expenses-Requesting Party
   - **Copies** of the bills, receipts, and the Explanation of Benefits that you received from the insurance company.
4. If either party files a motion and schedules a court hearing in this matter, that party must provide written notice to the other party and the county child support agency, if providing services, at least 14 days prior to the hearing date. The party that schedules the hearing must also file:
   - A **copy** of the Affidavit of Health Care Expenses
   - A **copy** of the Notice of Intent to Collect Unreimbursed and/or Uninsured Medical/Dental Expenses-Requesting Party
   - **Copies** of the bills, receipts, and the Explanation of Benefits from the insurance company.

   The supporting documents must be filed with the court no less that five days before the hearing. Please allow additional time when mailing the documents.

The Collection Process

The county child support agency will do the following:

- Notify the other party to pay the debt in full or file a motion with the appropriate court
- Add the amount shown on the Affidavit of Health Care Expenses to the child support account for enforcement
- Use all appropriate enforcement remedies to collect the amount
- Inform the other party of the right to file a motion in court if he or she disputes the amounts requested.

In some cases, the other party may enter into a payment agreement with the county child support agency.

Distribution Rules

When money is collected, it will flow through the normal distribution rules. This means that the payment on the unreimbursed and/or uninsured medical/dental expenses may be applied to current support or other past due support on your case or another case if the other party has another child support obligation. This distribution requirement will not affect the balance of the arrears owed to you, but will only affect the order in which it is paid.

Direct Payments

If the requesting party receives payment directly from the other party after submitting the debt to the county child support agency for collection, notify the county child support agency immediately in writing. Indicate the amount and date of the payment.

Questions

Direct any questions to the Child Support Officer assigned to the case.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA4 (9-15)

ADA Advisory

For accessible formats of this publication, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator.

Clear Form

Minnesota Department of **Human Services**

DHS-4931A-ENG 6-16

State of Minnesota **District Court**

County	Judicial District: Court File Number: Case Type:

☐ In Re the Marriage of:

_____

Plaintiff/Petitioner

vs/and

_____

Defendant/Respondent

_____

Intervenor

Affidavit of Health Care Expenses

Child Support (IV-D) Case Number: _____

County Attorney File Number: _____

STATE OF MINNESOTA)

COUNTY OF _____) SS

(COUNTY WHERE AFFIDAVIT SIGNED)

_____, states that he/she is the _____ in the above entitled action; that to the best of his/her knowledge, information and belief, total medical/dental expended by _____ on behalf of the dependents:

Children's Name(s)	Birth Date	Children's Name(s)	Birth Date

for the period from _____ through _____ is $_____. That by order of the court in this action, the _____ has been ordered to pay for a portion of the said expenses. The party is to pay _____% (percentage) of the medical/dental expense. Therefore, I am requesting the party pay $_____, within 30 days or agree to a payment schedule with me until the requested amount is paid in full.

The attached documents provide further proof and details of the medical/dental expenses, and are incorporated into this Affidavit.

I declare under penalty of perjury that everything I have stated in this document is true and correct. Minnesota Statutes, Section 358.116.

Sworn/affirmed before me on this

_____ day of _____, 20_____.

_____

Notary Public/Deputy Court Administrator

My commission expires: _____

SIGNATURE
PRINT NAME

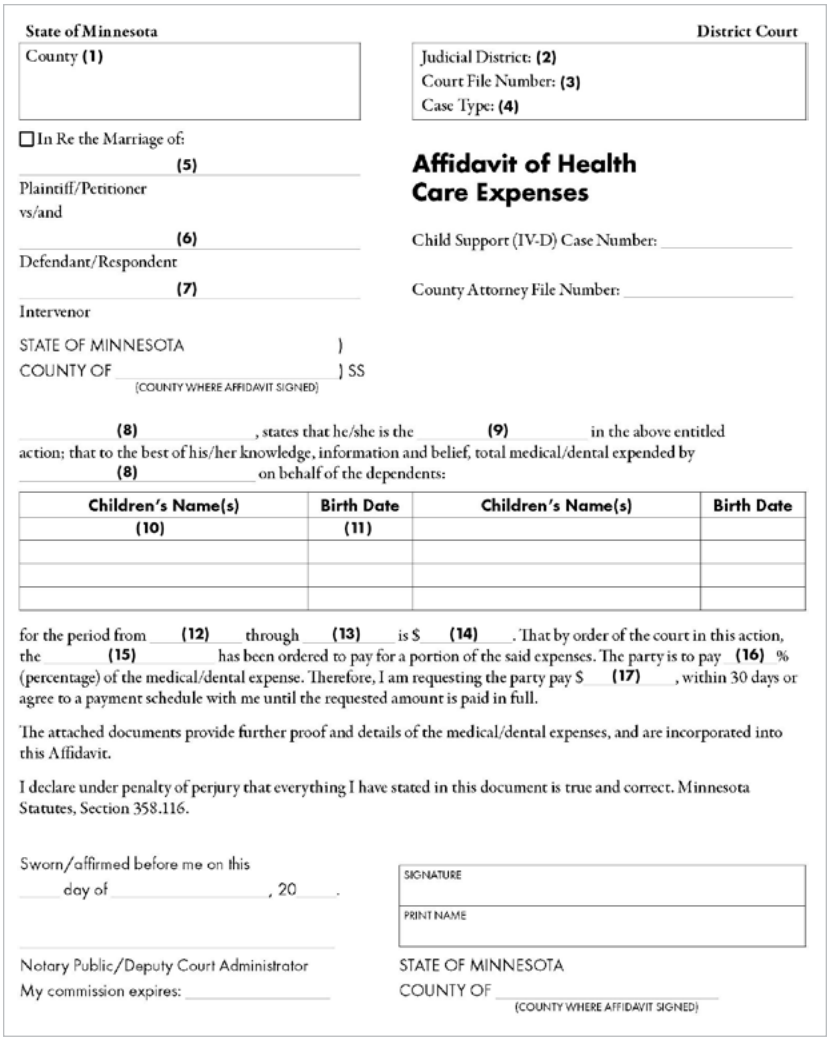
STATE OF MINNESOTA

COUNTY OF _____

(COUNTY WHERE AFFIDAVIT SIGNED)

Instructions for the Affidavit of Health Care Expenses

Note: You must sign this form in front of a notary.



State of Minnesota — District Court

County (1)

Judicial District: (2)
Court File Number: (3)
Case Type: (4)

☐ In Re the Marriage of:

(5)
Plaintiff/Petitioner
vs/and
(6)
Defendant/Respondent
(7)
Intervenor

Affidavit of Health Care Expenses

Child Support (IV-D) Case Number: _____

County Attorney File Number: _____

STATE OF MINNESOTA)
COUNTY OF _____ } SS
(COUNTY WHERE AFFIDAVIT SIGNED)

(8) , states that he/she is the (9) in the above entitled action; that to the best of his/her knowledge, information and belief, total medical/dental expended by (8) on behalf of the dependents:

Children's Name(s)	Birth Date	Children's Name(s)	Birth Date
(10)	(11)		

for the period from (12) through (13) is $ (14) . That by order of the court in this action, the (15) has been ordered to pay for a portion of the said expenses. The party is to pay (16) % (percentage) of the medical/dental expense. Therefore, I am requesting the party pay $ (17) , within 30 days or agree to a payment schedule with me until the requested amount is paid in full.

The attached documents provide further proof and details of the medical/dental expenses, and are incorporated into this Affidavit.

I declare under penalty of perjury that everything I have stated in this document is true and correct. Minnesota Statutes, Section 358.116.

Sworn/affirmed before me on this
day of , 20 .

Notary Public/Deputy Court Administrator
My commission expires: _____

SIGNATURE

PRINT NAME

STATE OF MINNESOTA
COUNTY OF _____
(COUNTY WHERE AFFIDAVIT SIGNED)

Complete the following blanks using a copy of your current court order as a reference:

1 Name of the county that is named on the caption of your current court order.

2 Judicial district just as it appears on the caption of your current court order.

3 Court file number just as it appears on the caption of your current court order.

4 Case type exactly the way it is on your current order here.

5 & 6 Name of the person who is listed in this same spot on your current court order. For example, if your name was listed first on the current court order, your name would go here. If the other parent's name was first on the current order, then the other parent's name would be copied on line 5.

7 This may not be used. If there is no intervenor listed in the caption of your current order, leave this space blank. If an intervenor is listed in the caption of your current court order, copy the name of the intervenor from your current order into this blank.

8 Your name as the requesting party.

9 Your legal role. For example, if you are listed as the plaintiff, petitioner, defendant or respondent in the caption of the current order, put that name in this blank.

10 Full name(s) of the child(ren) that incurred the medical expenses.

11 Date of birth(s) of the child(ren).

12 Date of the first medical expense that was incurred for which you are requesting payment.

13 Date of the last medical expense that was incurred for which you are requesting payment.

14 Total amount of the medical expenses for the child(ren). The total will be the amount owing after the insurance company's portion has been subtracted.

15 Liable party's legal role that is listed on the court order (using plaintiff, petitioner, defendant or respondent).

16 Percentage the other party is liable to pay for the unreimbursed/uninsured medical expenses from the current court order.

17 Total amount you are asking the other (liable) party to pay. To calculate multiply the percentage from Line #16 times (x) the total expenses stated in Line #14.

Statement of Medical/Dental Expenses

(Attach to Affidavit of Health Care Expenses)

The Statement of Medical/Dental Expenses is part of your Affidavit of Health Care Expenses form and must be included when submitting your request to the non-requesting (liable) party. Copies of bills, receipts, and the Explanation of Benefits that you received from your insurance provider must be attached to this document.

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

DATE OF EXPENSE	TYPE OF EXPENSE		
PROVIDER NAME			
PROVIDER ADDRESS			
CITY		STATE	ZIP CODE
TOTAL AMOUNT	INSURANCE OFFSET		
NCP OWES	CP OWES		

TOTAL NON-CUSTODIAL PARENT OWES	SIGNATURE OF THE REQUESTING PARTY	DATE
TOTAL CUSTODIAL PARENT OWES	PRINT REQUESTING PARTY'S NAME	

Instructions for Completing the Statement of Medical/Dental Expenses

The following blank lines will need to be completed by you, the requesting party:

Date of expense	The date the expense incurred.
Type of expense	The type of expense (for example, doctor visit or eyeglasses).
Provider name and address	The name and address of the provider (where the expense occurred).
Total amount	The total amount of the expense.
Insurance offset	The amount of the expense that the insurance company is covering.
Non-custodial parent (NCP) owes	The amount the NCP owes. This is calculated by subtracting the amount the insurance company is covering from the total amount of the expense then multiplying that amount by the percentage the court order states the party (NCP) is liable for.
Custodial parent (CP) owes	The amount the CP owes. This is calculated by subtracting the amount the insurance company is covering from the total amount of the expense then multiplying that amount by the percentage the court order states the party (CP) is liable for. This amount added with the amount that the NCP owes should equal the total uninsured amount of the expense.

Clear Form

Minnesota Department of **Human Services**

DHS-4931B-ENG 6-16

Notice of Intent to Collect Unreimbursed and/or Uninsured Medical/Dental Expenses

Requesting Party

NAME OF NON-REQUESTING PARTY		
ADDRESS OF NON-REQUESTING PARTY		
CITY	STATE	ZIP CODE

CHILD SUPPORT CASE NUMBER
DATE MAILED TO NON-REQUESTING PARTY

DATE

Purpose

This notice does the following:

- Notifies you of the portion of unreimbursed and/or uninsured medical/dental expenses that you owe
- Tells you what you must do
- Gives you information about what to do if you disagree with the amount.

Notice of obligation

As the Requesting Party, I am attempting to collect your portion of the unreimbursed and/or uninsured medical/dental expenses under the Court Order. I have enclosed an Affidavit of Health Care Expenses as an explanation for the amount(s) being requested. Based on your court ordered share, the amount that you must pay is $_____. Please pay that amount in full to me as soon as possible or contact me to set up a payment schedule.

If you do not respond within 30 days

You have 30 days from the date this Notice was mailed to you (not the date you actually received the notice) to either:

- Pay the requested amount in full
- Enter into a payment schedule with me or
- File a motion requesting a court hearing to contest the amount due or to set a court-ordered monthly payment amount.

Please note: If you do not respond within 30 days, I may submit the amount due above to the Child Support Agency for collection, if the Child Support Agency is providing support enforcement services.

If you disagree

If you disagree with the amount you must pay, within the time allowed by law, please file a motion to request a court hearing to contest this matter.

Questions

Direct any questions to me by mail or phone.

NAME OF REQUESTING PARTY		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE