

EXPLANATION OF HEALTH CARE EXPENSES

Case No.: _____

Name of Child _____ (DOB: _____)

Submitted by: _____

Date of Treatment (Chronological order)	Name of Provider & nature of service provided	TOTAL BILL Check box if bill attached	Date bill sent to PLAINTIFF/ DEFENDANT (Circle one)	Amount paid by insurance Check box if Explanation of Benefits attached	Amount adjusted by provider	Amount paid by PLAINTIFF	Amount paid by DEFENDANT	UNPAID BALANCE	Amount due from PLAINTIFF/ DEFENDANT (Circle one)
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TOTALS:									

Instructions

1. Use a separate sheet for each child and each year.
2. Attach all bills and all insurance Explanations of Benefits if available.
3. List each service provided in chronological order.

Notes: _____

