AFFIDAVIT OF HEALTH CARE EXPENSES and DEMAND FOR PAYMENT

Minn. Stat. § 518A41, subd. 17

1. My full name is _____
2. I am party to Court Case No: _____ in _____ County, Minnesota and this case includes a child support order.
3. The other parent, _____ is required by Court order(s) to pay _____ % of our joint children's unreimbursed or uninsured health care expenses, and I am required to pay _____ %
4. To the best of my knowledge, information, and belief the following is a list of the joint children's unreimbursed or uninsured health care expenses for which the other parent has not paid his/her full share:

Name of Joint Child Who Received the Care	**Date Care Was Provided** (Limited to costs within the past 2 years)	**Name of Provider** (doctor, dentist, clinic, hospital)	**Description of Medical/ Dental Care Received**	**Amount Not Covered by Insurance** (Out of pocket expense)
If you need more space, add additional sheets of paper.			**Total Amount:**	$0.00

5. The total amount of unreimbursed or uninsured health care expenses from the period _____ through _____ is _____

6. My share of this expense is _____ , and the other parent's share is _____

7. The other parent has paid me _____ towards these expenses.

8. Therefore, I am asking that within 30 days, the parent pay me _____ for his/ her portion of the unreimbursed or uninsured health care expenses or agree to a payment schedule with me until the requested amount is paid in full.

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

I declare under penalty of perjury that everything that I have stated in this document is true and correct. Minn. Stat. § 358.116.

Dated: _____

_____
County and State where signed

_____
Signature

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

E-mail address: _____