Name of Child: _____ **Case No. _____**

Explanation of Medical Bills

Date of Treatment (Chronological Order)	Name of Service Provider (Doctor, Dentist, Hospital, & services provided)	Total Bill	Date Bill Sent to Plaintiff/Defendant (circle one)	Insurance Amount Paid	Amount Defendant Paid	Amount Plaintiff Paid	Amount of Bill Unpaid	Amount Due From Plaintiff/Defendant (circle one)

_____ _____
Moving Party **Date**

Total Amount Claim _____
Applicable Annual Deductible _____
Net Amount of Claim _____