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:_____
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