Medical Expense Sheet

Child's Name	Treatment Date (Chronological)	Service Provider	Total Bill	Date Sent To Other Parent	Ins. Co. Paid	Defendant Paid	Plaintiff Paid	Unpaid Bill	Amount Due From Plaintiff/Defendant
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									
17.									
18.									
		Totals							

Case Name _____ **Case #** _____ **Family File #** _____