ANNA MCKINNEY, DIRECTOR

STEPHANIE KALISZEWSKI, ASSISTANT DIRECTOR

ERIE COUNTY COURT OF COMMON PLEAS
SIXTH JUDICIAL DISTRICT
Domestic Relations Section
Erie County Courthouse
140 West 6th Street, Room 06
Erie, Pennsylvania 16501
(814) 451-6151 Fax (814) 451-7651

UNREIMBURSED MEDICAL EXPENSE INSTRUCTIONS

1. Per rule PA 1910.16-6(c)(1), unreimbursed medical expenses include: insurance co-payments and deductibles and all expenses incurred for reasonably necessary medical services and supplies including; but not limited to, surgical, dental and optical services and orthodontia. **Medical expenses do NOT include cosmetic, chiropractic, psychiatric, psychological or other services unless specifically directed in the order of court.**
    a. **Any party wishing to collect cosmetic, chiropractic, psychiatric or psychology expenses must file a petition to have these expenses mediated by the Domestic Relations Office.**

2. The plaintiff is required to pay the first $250 in out-of-pocket medical expenses per year/per party on the support case before the defendant has to pay their proportionate share. Include all medical expenses on the attached summary sheet along with the bills and proof of payments showing the $250 has been met.
    a. Expenses shall be calculated on a calendar year basis. In the year in which the initial support order is entered, or in any period in which support is being paid that is less than a full year, the $250 threshold shall be pro-rated.

3. **Per rule 1910.16-6(c)(3) and 1910.16(d)(2), documentation of unreimbursed expenses that either party seeks to have allocated between the parties shall be provided to the other party NO later than March 31st of the year following the calendar year, sent by certified mail. (Please retain any mail that is retuned to you as this will need to be submitted to our office.)**

4. The Petitioner should send a completed unreimbursed packet to the Respondent by Certified Mail, return receipt requested. The completed packet should consist of the attached summary sheet **(Please use a separate Health Care Summary form for each dependent per year)**, bills from the provider displaying patient's name, services rendered, date of service and proof of any payments made. You must allow the Respondent 30 days to remit payment or to make payment arrangements to satisfy their share of the out of pocket expenses.

5. If the respondent failed to remit payment or make payment arrangements within the 30 day time period please send in the following to: Erie County Domestic Relations, Attn: Medical Unit, 140 West 6th St. Room 06, Erie, PA 16501.
    a. Copy of the packet which was sent to the respondent
    b. Proof of Service to the Respondent via certified mail.
        i. Please note that notification through any type of electronic services or devices does not constitute service and will be return to the petitioner to obtain service.
    c. Health Insurance Information Form
    d. HIPAA Release

6. All necessary information, including The Health Care Summary Form, Proof of Service and all necessary bills must be sent to the Domestic Relations Office in order to be processed. Should any of these items be missing your packet will be returned to you to obtain the missing information.
    a. **Please be aware that Explanations of Benefits (EOBs) cannot be used to show proof of payment or amount due for a provider. You must include copies of the bills directly from the provider.**

7. You are required to inform this office if the respondent pays any portion of the bills directly to you within the 30 day time period. You are also required to inform this office if any insurance reimbursement checks are received. Failure to do either of these can result in contempt of court action.

8. Once the packet has been received by the Domestic Relations Office – it will be reviewed to determine if the amounts owed are correct and are in compliance with the current support order. If any corrections need to be made the Domestic Relations Office will reach out to that petitioner regarding any changes. The Medical Unit will then enforce your request in accordance with local procedures.
    a. Once all of the information is verified a letter will be sent to the respondent requesting payment or to contact the Domestic Relations Office within 15 days of the letter. The respondent can then dispute any medical bills at that time.
        i. Should there be a dispute regarding the medical bills, a conference will be scheduled with the Domestic Relations Conference Unit.
        ii. If there is no dispute – the expenses shall be added to the order either as arrears or a monthly charge. This will be determined by the Medical Officer and will be explained in the 15 day letter.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize the Erie County Domestic Relations Section to disclose the following Protected Health Information from the records of:

   Name:________________________________ Date of Birth: _______________________

   Address:____ ________________________

   Telephone:__________________________ Case Number: _____________ ________

2. I request that the following information be disclosed:

   All necessary Protected Health Information as it relates to the establishment and enforcement of this support obligation.

3. This information is to be disclosed to Erie County Domestic Relations Section Business Associates, Law Enforcement Agencies and all parties to this support action, at my request.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, I understand that this authorization will expire when my case is closed.

5. The Commonwealth, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

6. I understand that the Commonwealth and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

7. I understand that I may inspect or copy my personal health information and may also choose not to sign this authorization. If I do not sign this authorization, the County Domestic Relations Section will not release the information.

8. If this authorization is to be signed by a personal representative, please describe the authority to act for the client.

Plaintiff: _________________________________ Defendant: ________________________

_______________________________________ __________________________________
Signature of Client or Personal Representative Date

MB-001

HEALTH CARE INSURANCE INFORMATION

Provide our office with identifying information of all known sources of insurance coverage in effect for the dependent(s) listed on the court order.

Fill in the information below and return it with the completed health Care summary form(s) and qualifying bills.

Plaintiff: ______________________________ **Defendant:** ____________________________________

PACSES CASE NUMBER: ________________________________

INSURANCE COVERAGE CARRIED ON THE DEPENDENT(S) BY:

- **THE DEFENDANT**

Insurance Company Information

Name of Carrier: ____

Address: ____

Group #: _____________ Policy # ____________ Effective date _________________

Type of Coverage in effect: ______medical ______optical ______dental ______prescription

- **THE DEFENDANT'S SPOUSE**

Insurance Company Information

Name of Carrier: ____

Address: ____

Group #: _____________ Policy # ____________ Effective date _________________

Type of Coverage in effect: ______medical ______optical ______dental ______prescription

- **THE PLAINTIFF**

Insurance Company Information

Name of Carrier: ____

Address: ____

Group #: _____________ Policy # ____________ Effective date _________________

Type of Coverage in effect: ______medical ______optical ______dental ______prescription

- **THE PLAINTIFF'S SPOUSE**

Insurance Company Information

Name of Carrier: ____

Address: ____

Group #: _____________ Policy # ____________ Effective date _________________

Type of Coverage in effect: ______medical ______optical ______dental ______prescription

If a medical ACCESS CARD or GATEWAY CARD is active, provide the following information:

ACCESS NUMBER _______________________ GATEWAY NUMBER ______________________

EFFECTIVE DATE _______________________ EFFECTIVE DATE ______________________

HEALTH CARE SUMMARY FORM

Case #: ___________________ **Submitted By:** ____________________

Plaintiff: __________________________ **Defendant:** ________________________

Unreimbursed % Responsibility: _____ **Unreimbursed % Responsibility:** ______

Year Expenses Incurred: ___________ **Dependent/Patient:** _____________________

(Summary Form for Each Dependent)

Provider	Date of Service	Total Amount of Bill	Amount Applied to Yearly Deductible	Amount of Uninsured to Split per Parties Proportions	Amount Respondent Owes	Payments Made By The Respondent
Totals:						

Please be aware there is a $250.00 deductible per child per calendar year. In the year in which the initial support order is entered, or in any period in which support is being paid that is less than a full year, the $250 threshold shall be pro-rated.

Calculation: Total Charges - Amount Paid by Insurance - Yearly Deductible = **Unreimbursed Expenses.** Total Unreimbursed Expenses multiplied by each parties unreimbursed % responsibility. Then deduct any payments made by either party to determine total amount owed.

HEALTH CARE SUMMARY FORM

Case #: ___________________ **Submitted By:** ____________________

Plaintiff: __________________________ **Defendant:** ________________________

Unreimbursed % Responsibility: _____ **Unreimbursed % Responsibility:** ______

Year Expenses Incurred: ___________ **Dependent/Patient:** _____________________

(Summary Form for Each Dependent)

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HEALTH CARE SUMMARY FORM

Case #: ___________________ **Submitted By:** ____________________

Plaintiff: ___________________________ **Defendant:** ________________________

Unreimbursed % Responsibility: _____ **Unreimbursed % Responsibility:** ______

Year Expenses Incurred: ___________ **Dependent/Patient:** _____________________
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