Uninsured Medical Expense Table

Date of Service	Name of Patient	Name of Health Care Provider	Total Amount of Bill	Amount Not Covered by Insurance	Amount Paid by Me	Date Claim was Submitted to Other Parent	How Claim was Submitted to Other Parent (for example, by mail from me, by health provider, etc.)	Amount I Believe the Other Parent Owes
								22
TOTALS				$	$			$

Use additional copies of this Table if all the claims cannot fit on one page. To support your motion, you should attach, if available, a copy of the Explanation of Benefits form from the Insurance carrier for each claim to verify the amount paid by insurance and the remaining uninsured portion that is the responsibility of the parties.