

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

Request for Collection of Uninsured Health Care Expenses

TO:

RE:

CASE NUMBER:

The Division of Child Support (DCS) may be able to collect uninsured health care expenses you paid for your children if you have not received payment from the parent required to pay the expenses under an existing child support order. Uninsured health care expenses include medical, dental, vision, pharmacy expenses, copayments, deductibles, and insurance premiums. You may include payments for medical equipment if you provide proof that the equipment was prescribed by a health care professional.

Please read all information below and follow all instructions to avoid having your request denied.

You can ask DCS to collect these expenses when **all of the following are true**:

1. You are a parent of a child for whom you incurred health care expenses.
2. You have a Washington State child support order that requires the other parent to pay part or all of the health care expenses.
3. You have paid a minimum of \$500.00 of uninsured health care expenses for that parent's children.
4. Your child received the health care services within the last 24 months.
5. The last reimbursement order for health care expenses was at least 12 months ago.
6. You requested payment directly from the other parent for these expenses **or** can show "good cause" why you did not.
7. You have not received full payment from the parent who is required to pay under the order.

Instructions

Use the enclosed ***Detail Sheet - Uninsured Health Care Expenses*** form to list your children's health care expenses. Use a separate form for each parent from whom you are requesting reimbursement.

Complete, date, sign, and return the ***Detail Sheet - Uninsured Health Care Expenses***. Be sure to follow the instructions on the form. If you are requesting reimbursement of health insurance premiums you paid for your children, complete the Health Insurance Section.

Carefully read the ***Permission to Share Documents for Reimbursement of Medical Expenses***.

1. You must check one of the boxes on page 2.
2. You must date, sign, and return the form to DCS with the **Detail Sheet** and copies of bills, receipts, payments, or other documentation.

Enclose clearly readable photocopies of the detailed expense records and payment records.

1. DCS cannot return these records to you.
2. Do not use a highlighter on any of the records. It makes the document unreadable.

The records must show the children's names, dates of service, all charges, and all payments. These records may include:

1. An insurance company explanation of benefits (EOB) with proof you paid the Patient Responsibility amount.
2. A billing statement, receipt, or ledger from the health care provider that shows the children's names, charges, payments, and who made the payment (insurance or client).

DCS will send copies of the bills, receipts, EOBs and payment records to the parent who is required to pay. **Delete any personal information from the records that you do not want the other parent to see.** Keep the originals or copies (with all information visible) of the records for future use. When you delete personal information, also send DCS one copy with all information visible for our records. Examples of personal information include your address, telephone number, social security numbers, account numbers or banking information shown on your receipts, and sensitive medical information such as prescription numbers and certain diagnoses.

Send the completed forms and requested documents to DCS at the fax number or address listed below.

DATE

AUTHORIZED REPRESENTATIVE
DIVISION OF CHILD SUPPORT

DIVISION OF CHILD SUPPORT
PO BOX 11520
TACOMA WA 98411-5520

Within _____ calling area _____

Outside _____ calling area _____

Fax: 866-668-9518

TTY/TDD services available for the speech or hearing impaired.

Visit our web site at: www.dshs.wa.gov/esa/division-child-support

No person because of race, color, national origin, creed, religion, sex, age, or disability, shall be discriminated against in employment, services, or any aspect of the program's activities. This form is available in alternative formats upon request.