Washington State Department of Social & Health Services
Transforming lives

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

Detail Sheet – Uninsured Health Care Expenses

Instructions (Please read carefully)

1. Use a separate ***Detail Sheet*** for each parent from whom you are requesting reimbursement. List the expenses of all of that parent's children on the form. List the health insurance premiums separately in the Health Insurance Section. You must also provide the medical and/or dental insurance information where indicated.
2. If you need more pages, make a copy of this form before you begin or download the form from the DCS web site at https://www.dshs.wa.gov/esa/division-child-support/division-child-support-forms
3. Except for your signature, print all responses with blue or black ink only.
4. Provide complete information for each column below. Enter the total for each column where shown.
5. List the expenses in the order that the medical services were received (oldest date to newest date).
6. You must submit records to support each claim (bills, receipts, explanation of benefits (EOBs), cancelled checks, etc.). To speed processing, please number each document in the upper right corner with the same Expense and Receipt Number as the expense listed on page 2. **Do not use a highlighter on any of the records. It makes the document unreadable.**
7. If requesting reimbursement for a large expense, such as orthodontia, and are paying according to a contract or agreement, submit a copy of the payment contract or agreement.
8. If requesting reimbursement of insurance premiums you pay for your children, complete the Health Insurance Section of this form. You must be the subscriber to the policy to ask for reimbursement. If a premium amount is shown on line 10.a. of the Child Support Schedule Worksheet for either parent, you cannot request premium reimbursement.
9. Complete the Declaration Section on page 3. Check the box stating you requested payment directly from the other parent or check the box stating you did not request payment from the other parent because you have "good cause." DCS needs this information if an order is entered and a parent requests an Administrative Hearing. You must date and sign where indicated.
10. CS will send a copy of pages 2 and 3 of this "Detail Sheet," the bills, receipts, EOBs, and payment records to the parent who is required to pay. Delete all 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.

NAME OF PARENT REQUIRED TO PAY	DCS CASE NUMBER

YOUR NAME

Expenses and Payments					
EXPENSE AND RECEIPT NUMBER	CHILD'S NAME	DATE OF SERVICE (DATE CHILD RECEIVED THE SERVICE OR DATE PRESCRIPTION WAS FILLED)	TOTAL AMOUNT OF EXPENSE OR COPAYMENT AMOUNT	TOTAL AMOUNT PAID BY YOU	DCS USE DENIAL REASON
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
		COLUMN TOTALS	$	$	

Amount the other parent paid directly to you for the above health care expenses: **$**

Reminder: You must sign the **Declaration** on Page 3 for DCS to process your claim.

DCS Expense Denial Reasons

D1: Date of service is more than 24 months old.
D2: No document showing this expense.
D3: No proof of payment for this expense.
D4: Not an eligible expense (Ex: not prescribed by a physician, late fees)
D5: No support order covering this date of service
D6: The other party already paid their share of this expense.
D7: You are not the subscriber to the insurance policy.
D8: The other parent is providing insurance so is not obligated to pay a portion of your premium payment.
D9: A premium amount for you or the other parent is shown on line 10.a. of the Child Support Schedule Worksheet.
D10: Other

Health Insurance Section

I am requesting reimbursement of health insurance premiums. I listed the following medical and / or dental insurance information for my children. My insurance company name, address, and telephone number; my member ID; and my group number as shown on my insurance identification card.

SUBSCRIBER NAME		DATE INSURACNE COVERAGE BEGAN
MEDICAL INSURANCE COMPANY NAME AND ADDRESS		
TELEPHONE NUMBER ( )	MEMBER ID	GROUP NUMBER
DENTAL INSURANCE COMPANY NAME AND ADDRESS		
TELEPHONE NUMBER ( )	MEMBER ID	GROUP NUMBER

Health Insurance premiums

CHILD'S NAME	INSURANCE COMPANY NAME	COVERAGE PERIOD MONTH / YEAR TO MONTH / YEAR	COST PER MONTH FOR CHILDREN ONLY	TOTAL AMOUNT PAID BY YOU	DCS USE DENIAL REASON

Amount the other parent paid directly to you for these health insurance premiums: $

Declaration

I have not received any payments for these expenses other than what is shown above and on page 2. **Check one of the boxes below.**

☐ I requested payment directly from the other parent for these expenses.

☐ I have "good cause" for not requesting payment directly from the other parent for these expenses.

I declare, under penalty of perjury under the laws of the state of Washington, that the foregoing is true and correct.

SIGNED AT (CITY / STATE)	DATE
YOUR SIGNATURE	YOUR PRINTED NAME

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.