Domestic Relations Section
Court of Common Pleas of Bucks County
100 North Main Street, Doylestown, PA 18901
(215) 340 - 8068

Plaintiff Name:
Defendant Name:
Docket Number:
PACSES Case Number:

Summary of Medical and/or Dental Bills
(A separate form must be submitted for each child/spouse in which you seek to receive reimbursement.)

The following bill(s) incurred by ______________ (your name) for ____________________ (child/spouse's name) has/have been sent to ____________________ (other party's name) and he/she/they has failed to pay it/them as ordered. Copies of the bill(s) and verification of insurance payment(s) are attached.

We will not accept just a statement with a balance. It must be accompanied by a copy of the original bill(s) and a copy of the receipt(s). Documentation of medical expenses must be provided to the other party no later than March 31st of the year following the calendar year in which the final medical bill was received.

Date of Service	Provider	Total Amount	Unreimbursed Amount
		Total	$
		Less $250.00 (if applicable)	$
		Total to be shared	$
		Other party's proportionate share	x %
		Total Obligation Due	

I verify that the statements made are true and correct to the best of my knowledge. I understand that false statements herein are made to the penalties of 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities.

______________________ Date

______________________ Signature

www.buckscounty.gov/1501/Contact-My-DRS-Form

EN-024C