SUMMIT COUNTY DOMESTIC RELATIONS COURT
EXPLANATION OF MEDICAL BILLS FORM

Name of Child	Date of Treatment (Chronological Order)	Name of Service Provider (Doctor, Dentist, Hospital, etc.)	Total Bill	Date of Bill To Plaintiff/ Defendant Mother/ Father	Insurance Amount Paid	Amount Paid Mother	Amount Paid Father	Amount of Bill Unpaid	Amount Due From Mother/ Father

August 31, 2000