EXPLANATION OF MEDICAL BILLS

NAME OF CHILD	DATE OF TREATMENT (Chronological Order)	NAME OF SERVICE PROVIDER (Doctor, Dentist, Hospital & services provided)	TOTAL BILL	DATE BILL SENT TO Plaintiff/ Defendant	AMOUNT INSURANCE PAID	AMOUNT PLAINTIFF PAID	AMOUNT DEFENDANT PAID	AMOUNT OF BILL UNPAID	AMOUNT DUE FROM Plaintiff/ Defendant (circle one)

TOTAL AMOUNT OF CLAIM: 0