# UNREIMBURSED MEDICAL ITEMIZATION FORM

**YEAR** ______________

PLAINTIFF __________________________ DEFENDANT _______________________________ CASE # ___________________

**DEPENDENT FOR WHOM EXPENSES INCURRED** _________________________________________
**(only one per page)**

Deductible Met: Yes ☐ No ☐

**Plaintiff's share of unreimbursed expenses** ______________ **%**
**Defendant's share of unreimbursed expenses** _____________ **%**

| Medical Service Date | Service Provider & type of service | Total Bill Amount | Insurance Reimbursement Amount | Total Balance | Plaintiff Paid | Defendant Paid | Balance Due by Defendant | Payable to Whom |
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| **Total:** | | | | | | | | |

**Plaintiff signature**__________________________ **Date**_________________

MB-001 / MED EXP