

**IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA
FAMILY DIVISION, ADULT SECTION**

Phone: (412) 350-5600

Fax: (412) 350-6471

Plaintiff Name: _____

Defendant Name: _____

Docket Number: _____

PACSES Case Number: _____

Other State ID Number: _____

Please note: All correspondence must include the PACSES Case Number.

SUMMARY OF MEDICAL AND/OR DENTAL BILLS

The following bill(s) has/have been sent to _____ and he/she has failed to pay the apportioned costs 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.

PAYABLE TO: (Name of Health Care Provider)	PERSON TREATED (Name of Spouse or Dependent Child)	AMOUNT PAID BY INSURANCE	BALANCE DUE (Amount Not Paid by Insurance)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Date:

Signature