Claim For Reimbursement of Health Care Costs

Month/Date of Health Care Expense	Name of Health Care/Medical Provider	Amount Paid By Me To Provider	Check if Proof of Payment is Attached	Amount Covered By Health Insurance	Amount Due From Other Parent	Comments

I declare under penalty of perjury under the laws of the State of California that all claimed expenses are true and accurate and that they were related to necessary health care provided to only the child/ren of this relationship.

_____ Dated:_____

Name of Claimant