Ordinary Medical Expense (OME) Tracking Sheet

FORM 1

Calendar Year _____ OME_____ Docket Number _____

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Amt. Paid by Insurance	Amt. Paid by Custodial Party
Jon	Dr. Smith	Jan 15	Office Visit, Wart Removal	0	150.00

All verification of expenses listed above and proof of payment has been attached.

_____ Date _____ Signature