RE: _____ **EXHIBIT_____**

**SPREADSHEET FOR MEDICAL EXPENSES GIVEN TO _____**

| # | DATE OF BILL | SERVICES PROVIDED | NAME OF CHILD | AMOUNT OF BILL NOT PAID BY INSURANCE | AMOUNT YOU PD, IF ANY | DATE SUBMITTED TO OBLIGOR | AMOUNT OBLIGOR PD | SUBTOTAL OWED BY OBLIGOR |
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| | DATE OF BILL | PLACE OF SERVICE SERVICES PROVIDED | | AMOUNT OF BILL NOT PAID BY INSURANCE | AMOUNT YOU PD, IF ANY | DATE SUBMITTED TO OBLIGOR | AMOUNT OBLIGOR PD | SUBTOTAL OWED BY OBLIGOR |
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