

**PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE
 FLORIDA DEPARTMENT OF FINANCIAL SERVICES
 DIVISION OF WORKERS' COMPENSATION
 200 EAST GAINES STREET
 TALLAHASSEE, FL 32399-4232**

Department Use Only

I. HEALTH CARE PROVIDER INFORMATION: MUST BE "Health Care Provider" as defined in s.440.13(1)(g), Florida Statutes

Type of Health Care Provider: <input type="checkbox"/> Physician/Practitioner <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Hospital <input type="checkbox"/> Other Provider or Facility	
Name:	Florida Medical License Number:
Address (Street or P.O. Box):	Contact Name: (Last, First)
	Telephone Number:
City, State, Zip Code:	E-Mail Address:

II. ENTITY ACTING ON BEHALF OF HEALTH CARE PROVIDER *(Complete section if submitting petition on behalf of the Health Care Provider)*

Name (Last, First):	Company Name (if applicable):
Contact Address (Street or P.O. Box):	Telephone Number:
City, State, Zip Code:	E-Mail Address:

III. INJURED EMPLOYEE INFORMATION

Name:	Date of Service(s):
Carrier Claim #: (If known)	Date of Accident:

IV. COMPUTATION OF TIME FOR FILING PETITION

Receipt Date of the Explanation of Bill Review / Notice of Disallowance or Adjustment of Payment:	Document Received: <input type="checkbox"/> Explanation of Bill Review (EOBR) <input type="checkbox"/> Notice of Disallowance or Adjustment of Payment
Method Used to Establish Date: <input type="checkbox"/> Date Stamp	<input type="checkbox"/> Verifiable Log

V. SERVICE OF PETITION ON CARRIER

Name/Address of Entity Served:	United States Postal Service Certified Mail Tracking#:
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VI. REIMBURSEMENT PURSUANT TO CONTRACT OR RATE AGREEMENT *(If applicable, please provide information below.)*

List the parties to the contract or rate agreement: _____

List the name of network, if applicable: _____

List the effective date of the contract or rate agreement: _____

List contact information of the person who can substantiate the contract or rate agreement is in effect with this Health Care Provider:

Name: _____

Phone Number: _____

Email Address: _____

VII. DISPUTE SUMMARY *(Attach additional summary as needed.)*

Please indicate justification that forms the basis of this dispute and attach documentation supporting the additional reimbursement, pursuant to rule 69L-31, Florida Administrative Code:

VIII. DETAILED CALCULATION OF DISPUTED SERVICES *(Please provide calculations in the table below, or attach a detailed calculations sheet, displaying the correct reimbursement amounts you assert for the disputed services.)*

Date(s) of Service	Service/Treatment Codes In Dispute <i>(If applicable, include Modifier)</i>	Place of Service Code or Description <i>(If applicable)</i>	Unit(s)	Amount Billed	Amount Paid	Additional Amount Due
TOTAL						

By my signature below, I acknowledge that I am filing a Petition for Resolution of Reimbursement Dispute regarding workers' compensation medical services billable by me or the facility of which I am an authorized representative. I also confirm that I, or the facility of which I am an authorized representative, meets the definition of a Health Care Provider as defined in section 440.13, Florida Statutes.

Signature of Health Care Provider or Authorized Representative

Date

Print Name of Health Care Provider or Authorized Representative

FREQUENTLY ASKED QUESTIONS

PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE FORM (DFS –F6-DWC-3160-0023)

Who are Health Care Providers as defined in paragraph 440.13(1)(g), Florida Statutes?

For the purposes of the Florida Workers' Compensation system, a Health Care Provider means a physician or any recognized practitioner licensed to provide skilled services pursuant to a prescription or under the supervision or direction of a physician. The term health care provider also includes a health care facility which means any hospital licensed under Chapter 395 and any health care institution licensed under Chapter 400 or Chapter 429.

What documentation is required when filing the form DFS-F6-DWC-3160-0023 (Petition Form)?

The required documentation supporting the allegations contained in the Petition Form varies depending on the Health Care Provider (Provider) type and service(s) in dispute. Pursuant to Rule 69L-31.005(2), Florida Administrative Code, a hard copy of the following documentation shall accompany the Petition Form:

- Each Explanation of Bill Review (EOBR) or Notice of Disallowance or Adjustment of Payment received from Carrier or Entity Acting on Behalf of the Carrier
- All medical bills or request(s) for reimbursement sent to the Carrier or Entity Acting on Behalf of the Carrier for the service(s) in dispute on the EOBR or Notice of Disallowance of Adjustment of Payment
- All related documentation submitted to the Carrier or Entity Acting on Behalf of the Carrier in support of the medical services, bills or request for reimbursement
- If the dispute involves an authorization issue for non-emergency treatment, documentation of authorization from the Carrier or Entity Acting on Behalf of the Carrier
- If the dispute involves a Carrier notification issue pursuant to s. 440.13(3)(b), Florida Statutes, documentation of the provider's notification of emergency treatment or admission following emergency treatment to the Carrier
- If the dispute involves repackaged medication, the Prescription (Legend) Drug Pedigree documenting ownership and distribution history of the medication dispensed.
- If the dispute involves hospital services, the portion of the hospital charge master pertinent to the billed services as of the date of service
- If the dispute involves surgical implants, the acquisition invoice(s) from the health care facility for surgical implants/associated disposable instrumentation, and the record or implant log reflecting utilization of the items
- If the dispute involves supplies not incidental to the medical services, the acquisition invoice(s) from the Provider for items billed, and the record or medical services notes reflecting utilization of items

Is there a timeframe for filing a Petition Form?

The Petition Form and required supporting documentation must be filed with the Department by the Health Care Provider or the Entity Acting on Behalf of the Health Care Provider within forty -five days upon receipt of the EOBR or Notice of Disallowance or Adjustment of Payment from the Carrier or Entity Acting on Behalf of the Carrier.

Who should receive service of the Petition Form?

A copy of the Petition Form and required supporting documentation as filed with the Department should be sent via United States Postal Service certified mail to the carrier's designated entity on the EOBR/Notice of Disallowance or Adjustment of payment. If an entity is not designated, then the information should be mailed via USPS certified mail to the entity which issued the EOBR/Notice of Disallowance or Adjustment of Payment.

Where do I file the Petition Form and supporting documentation?

The Petition Form along with required supporting documentation shall be filed using the following addresses/methods:

Mailed to:

DIVISION OF WORKERS' COMPENSATION, MEDICAL SERVICES SECTION
C/O DEPARTMENT OF FINANCIAL SERVICES
200 EAST GAINES STREET
TALLAHASSEE, FLORIDA 32399-4232

Hand delivered Monday through Friday between 8:00 a.m. and 5:00 p.m., eastern time, excluding state holidays to:

RECEPTIONIST, HARTMAN BUILDING
2012 CAPITAL CIRCLE SOUTHEAST
TALLAHASSEE, FLORIDA