

CARRIER RESPONSE TO 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. CARRIER INFORMATION: MUST BE "Carrier" as defined in s.440.13(1)(c), Florida Statutes

Type of Carrier: <input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Self-Insurance Fund <input type="checkbox"/> Individually Self-Insured Employer <input type="checkbox"/> Assessable Mutual Insurer	
Name:	Division Assigned Carrier ID:
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 CARRIER (Complete section if submitting response on behalf of the carrier)

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

III. HEALTH CARE PROVIDER INFORMATION

Name of Provider filing the Petition for Resolution of Reimbursement Dispute:

IV. INJURED EMPLOYEE INFORMATION

Name (Last, First):	Date of Service(s):
Carrier Claim #:	Date of Accident:

V. COMPUTATION OF TIME FOR FILING CARRIER RESPONSE

Receipt Date of the Petition for Resolution of Reimbursement Dispute:	Service Method of Response to the Department: <input type="checkbox"/> United States Postal Service <input type="checkbox"/> Common Carrier <input type="checkbox"/> Hand Delivery
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VI. SERVICE OF CARRIER RESPONSE ON THE HEALTH CARE PROVIDER

Name/Address of Entity Served:	Delivery Tracking #:
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VII. REIMBURSEMENT AMOUNT

What does the Carrier or Entity Acting on Behalf of the Carrier assert is the correct reimbursement amount for the service(s) in dispute on the Petition Form? \$ _____
Attach a copy of the Explanation of Bill Review(s) or Notice(s) of Disallowance or Adjustment of Payment issued to the Health Care Provider or Entity on Behalf of the Health Care Provider for service(s) in dispute.

FREQUENTLY ASKED QUESTIONS

CARRIER RESPONSE TO PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE FORM (DFS –F6-DWC-3160-0024)

Who are Carriers as defined in s. 440.13(1)(c), Florida Statutes?

For the purposes of the Florida Workers' Compensation system, a carrier is an insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer authorized under s. 440.38, Florida Statutes, to insure under this chapter and s. 624.462. The carrier is also registered with the Division of Workers' Compensation and assigned a Division Carrier ID number.

What documentation is required when filing the Form DFS-F6-DWC-3160-0024 (Carrier Response Form)?

When filing a response, a hard copy of all documentation that supports the carrier's reimbursement decision and allegations contained in the Carrier Response Form. Such documentation shall include but is not limited to the following:

- Each Explanation of Bill Review (EOBR) or Notice of Disallowance or Adjustment of Payment of the service(s) in dispute issued to the health care provider or entity acting on its behalf
- All related documentation supporting the identified descriptions and codes in the EOBR or Notice of Disallowance or Adjustment of Payment of service(s) in dispute
- All medical bills or request(s) for reimbursement received from the Health Care Provider or Entity Acting on Behalf of the Health Care Provider for service(s) in dispute
- If the dispute involves an authorization issue for non-emergency treatment, documentation of a notice to Health Care Provider of de-authorization or non-authorization to render service(s) to the injured employee

Is there a timeframe for filing a Carrier Response Form?

The Carrier Response Form and supporting documentation must be filed with the Department by the Carrier or Entity Acting on Behalf of the Carrier within thirty days upon receipt of the Petition for Resolution of Reimbursement Dispute Form, DFS-F6-DWC 3160-0023 (Petition Form) via United States Postal Service certified mail from the Health Care Provider or Entity Acting of the Health Care Provider.

Who should receive service of the Carrier Response Form?

A copy of the Carrier Response Form and supporting documentation as filed with the Department should be mailed to the Entity Acting on Behalf of the Health Care Provider at the address in Section II of the Petition Form. If Section II is incomplete, mail to the Health Care Provider at the address in Section I of the Petition Form. The carrier response shall be mailed using a delivery method which provides confirmation of a delivery date.

Where do I file the Carrier Response Form and supporting documentation?

The Carrier Response Form along with supporting documentation shall be filed using one of 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