REQUEST FOR ASSISTANCE

EMPLOYEE ASSISTANCE OFFICE

DIVISION OF WORKERS' COMPENSATION

STATE OF FLORIDA

PLEASE PRINT THE FOLLOWING INFORMATION:

DO NOT WRITE IN THIS AREA	DATE STAMP

NAME:	SEQ#:	OFFICE ASSIGNED TO:	
EMPLOYEE TELEPHONE #: (OR CONTACT NUMBER)		DATE/ACCIDENT:	TIME/ACC:

EMPLOYEE STREET ADDRESS:	WORKERS' COMP. INSURANCE COMPANY:
	INSURANCE CO. TELEPHONE: ( )
CITY: ST: ZIP CODE:	INSURANCE CO. ADDRESS:
COUNTY OF EMPLOYEE RESIDENCE:	
EMPLOYER'S NAME (COMPANY) & ADDRESS:	CITY: ST: ZIP CODE:
	CLAIM REPRESENTATIVE'S (ADJUSTER) NAME:
EMPLOYER'S TELEPHONE #: ( )	

THE INFORMATION YOU SUPPLY WILL BE USED TO PROCESS YOUR REQUEST.
THE MORE COMPLETE AND SPECIFIC THE INFORMATION THE BETTER WE WILL BE ABLE TO SERVE YOU.
This form is to be used to request help to resolve a dispute over benefits due and not received from your Employer/Carrier.

ARE YOU REPRESENTED BY AN ATTORNEY? (CHECK BOX) YES ☐ NO ☐

ATTORNEY'S NAME/BAR NUMBER:
ATTORNEY'S ADDRESS AND TELEPHONE #:

WHO IS REQUESTING ASSISTANCE? (CHECK THE BOX THAT APPLIES):

☐Employee ☐Health Care Provider
☐Employer ☐Carrier/TPA
☐Other (Describe Here): _____

WHAT IS THE PROBLEM AREA? PLEASE CHECK THE BOX THAT APPLIES.

☐ENTIRE CLAIM DENIED? ☐MEDICAL BILL NOT PAID?
☐CHECK LATE? ☐NEED A DOCTOR?
☐OTHER?

IMPORTANT

PLEASE USE THE SPACE ON THE BACK OF THIS FORM TO EXPLAIN, IN DETAIL, WHAT YOU NEED AND WHY THE FOLLOWING ACTIONS SHOULD BE NOT FILED WITH THE EAO OFFICE:

****CLAIMS FOR S.D.T.F.**
****ALL MOTIONS TO J.C.C.**
****REQUESTS FOR ATTORNEY'S FEES AND COSTS**
****CLAIMS FOR CONTRIBUTION**
****AMENDED PETITIONS**

NAME:		DATE/ACCIDENT:	TIME/ACC:

PLEASE USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR PROBLEM:

FOR EXAMPLE: IF YOU FEEL YOU ARE OWED A CHECK, PUT THE DATE AND WHAT THE DOCTOR SAID YOUR WORK STATUS WAS AT THAT TIME. (NO WORK, LIGHT DUTY, AND EARNING LESS OR LOOKING FOR WORK, OR DOCTOR GAVE YOU PERMANENT RESTRICTIONS & YOU ARE LOOKING FOR WORK). IF THE PROBLEM IS ABOUT AN UNPAID MEDICAL BILL, HOW MUCH THE BILL IS, WHAT DOCTOR OR DRUGSTORE & THE DATES OF THE BILLS.

PROBLEM DEFINED:

_____
_____
_____
_____
_____
_____

NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE CO. OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

It is the duty of all who participate in the workers' compensation process to attempt to resolve disagreements in good faith. Have you contacted the insurance carrier, or employer's servicing company?

☐ YES ☐ NO

Date Contacted:
Adjuster/Representative's Name:
Adjuster/Representative's telephone number:

Reason for no contact:

_____
_____
_____
_____

SIGNATURE OF REQUESTOR: _____ DATE: _____

NAME, TITLE, ADDRESS, & TELEPHONE # OF REQUESTOR – IF NOT EMPLOYEE:

TELEPHONE: (_____)

_____

_____
_____
_____

WHEN YOU HAVE FULLY COMPLETED THIS FORM, PLEASE MAIL IT TO THIS ADDRESS, OR IF YOU NEED ASSISTANCE, PLEASE CALL AT 1 (800) 342-1741

EMPLOYEE ASSISTANCE OFFICE
DIVISION OF WORKER'S COMPENSATION
P.O. BOX 8010
TALLAHASSEE, FLORIDA 32314-8010