

REIMBURSEMENT REQUEST
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
OFFICE OF SPECIAL DISABILITY TRUST FUND
 200 East Gaines Street
 Tallahassee, Florida 32399-4223

SDTF RECEIVED DATE

Note: This report must be signed by the employer or his duly authorized agent or carrier. Supporting records are subject to audit by the Division of Workers' Compensation. The signed original and one copy must be filed with the Fund by the employer or carrier requesting reimbursement.

PLEASE PRINT OR TYPE

EMPLOYEE NAME		SDTF CLAIM NUMBER	DATE OF ACCIDENT	
NAME OF EMPLOYER		CARRIER CODE #	SERVICE CO/TPA CODE #	
COMPENSATION RATE		IMPAIRMENT RATING %	MMI DATE	PT DATE
BASE COMPENSATION RATE	COMPENSATION RATE WITH S/S OFFSET \$			
PERMANENT IMPAIRMENT (D/A Before 1/1/94)		TEMPORARY TOTAL		
PI DATE		From _____ To _____		
IMPAIRMENT INCOME (D/A On or After 1/1/94)		TEMPORARY PARTIAL		
From _____ To _____		From _____ To _____		
WAGE LOSS		MEDICAL (PHYSICIAN FEES)		
From _____ To _____		From _____ To _____		
SUPPLEMENTAL INCOME BENEFITS (D/A On or After 1/1/94)		HOSPITAL		
From _____ To _____		From _____ To _____		
PERMANENT TOTAL		DRUGS, BRACES, PROSTHESIS, OTHER SUPPLIES		
From _____ To _____		From _____ To _____		
PERMANENT TOTAL SUPPLEMENTAL		TRAVEL / MILEAGE		
From _____ To _____		From _____ To _____		
LUMP SUM SETTLEMENT (JPO)		ATTENDANT CARE		
Date _____		From _____ To _____		
DEATH		FUTURE MEDS		
From _____ To _____				
TOTAL PERMANENT COMPENSATION		TOTAL MEDICAL AND TEMPORARY COMPENSATION		
PERIOD FOR WHICH REIMBURSEMENT IS REQUESTED		TOTAL PERMANENT, TEMPORARY AND MEDICAL BENEFITS		
From _____ To _____				
TOTAL REIMBURSED PRIOR TO THIS REQUEST		TOTAL AMOUNT REIMBURSEMENT REQUESTED		
\$ _____		\$ _____		
THIRD PARTY RECOVERIES				
\$ _____				
NAME AND ADDRESS OF PAYEE:		CALCULATIONS/FORMULA		
PAYEE'S FEDERAL TAX ID# _____				
MAIL CHECK TO:		COMMENTS		
ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.				
I HEREBY CERTIFY THAT ALL OF THE SUMS LISTED ON THIS FORM HAVE BEEN PAID, AND I FURTHER CERTIFY THAT EXPENDITURES FOR ATTORNEYS FEES, PENALTIES AND INTEREST, DEPOSITION AND COURT COSTS HAVE NOT BEEN INCLUDED ON THIS				
PREPARER'S SIGNATURE:	SIGNED BY:	CARRIER NAME, ADDRESS & TELEPHONE #		
PREPARER'S TYPED NAME:	TITLE:			
PREPARER'S TELEPHONE #:	DATE:			

INSTRUCTIONS: ATTACH APPROPRIATE DOCUMENTATION

1. TT - DWC-4
2. TP - DWC-3
3. WAGE LOSS - DWC-3's
4. PTD PAYSHEET
5. DEATH PAYSHEET
6. PI - DRAFT COPIES AND DWC-4's

NOTE: DWC-3's AND DWC-4's MUST BE FULLY COMPLETED WITH SIGNATURE, DATE PAID AND AMOUNT PAID.

EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

PERIOD	COMPENSATION RATE	TEMPORARY TOTAL	TEMPORARY PARTIAL	WAGE LOSS	PERMANENT TOTAL	DEATH BENEFITS	PERMANENT IMPAIRMENT
TOTALS							

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PAYMENT SCHEDULE A

- INSTRUCTIONS: 1. COMPLETE THIS FORM.
 2. TOTAL AND ATTACH BILLS IN DATE OF SERVICE ORDER.
 3. ATTACH AUDIT TAPE.

EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

MEDICALS			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			

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EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

HOSPITAL			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			

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EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

RX AND MILEAGE			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			

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EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

MISCELLANEOUS (PLEASE SPECIFY)			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			