

CLAIM COST REPORT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION

200 East Gaines Street
Tallahassee, FL 32399-4226

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE ████

SOCIAL SECURITY #	EMPLOYEE NAME: (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
TYPE OF REPORT <input type="checkbox"/> INITIAL REPORT SUMMARIZING FIRST SIX MONTHS <input type="checkbox"/> ANNUAL REPORT ON OPEN CASE <input type="checkbox"/> FINAL REPORT- CASE CLOSED; NO ACTIVITY IN PAST YEAR OR CASE SETTLED		AVERAGE WEEKLY WAGE (Do not Round) COMPENSATION RATE (Do not Round)
FULL SALARY IN LIEU OF COMPENSATION FOR ANY PERIOD OF TIME? <input type="checkbox"/> YES		FULL SALARY END DATE ____ - ____ - ____
TYPE OF PAYMENT	WEEKS	DAYS
PAID TO DATE COLUMN I (Do not round)	TYPE OF PAYMENT	PAID TO DATE COLUMN II (Do not round)
TEMPORARY PARTIAL		MEDICAL ALL DWC-9 & 11
TEMPORARY TOTAL		HOSPITAL ALL DWC-90
TEMPORARY TOTAL - 80%		TRANSPORTATION MEDICAL APPTS.
TEMPORARY TOTAL- TRAINING & EDUCATION		DRUGS/SUPPLIES ALL DWC-10
IMPAIRMENT INCOME BENEFITS		HOME ATTENDANT CARE
STATUTORY PERMANENT IMPAIRMENT (D/A's prior to 01/01/94)		SKILLED NURSING CARE
WAGE LOSS (D/A's prior to 01/01/94)		MISCELLANEOUS MEDICAL
SUPPLEMENTAL INCOME BENEFITS		REHABILITATION ALL DWC-21
PERMANENT TOTAL Date accepted/adjud.: ____ - ____ - ____		MEDICAL SETTLEMENT AMT. Date Payment Mailed: ____ - ____ - ____
PERMANENT TOTAL SUPPLEMENTAL		TOTAL (PAID-TO-DATE COLUMNS I & II)
DEATH		
FUNERAL		(Amounts entered in paid-to-date columns I & II should not be reduced for recoveries except overpayment recoveries.)
COMPENSATION SETTLEMENT AMOUNT Date Payment Mailed: ____ - ____ - ____		THIRD PARTY RECOVERY AMOUNT: _____
PENALTIES (Paid to Claimant)		SPECIAL DISABILITY TRUST FUND RECOVERY AMOUNT: _____
INTEREST (Paid to Claimant)		ALL OTHER RECOVERIES EXCEPT OVERPAYMENTS: _____
INSURER CODE #	DATE PREPARED: (Month-Day-Year)	INSURER NAME
SERVICE CO./TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.
Form DFS-F2-DWC-13 (03/2009) Rule 69L-3.025, F.A.C.

DWC-13 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.