HEALTH CARE PROVIDER VIOLATION REFERRAL FORM
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION AT ADDRESS BELOW

PLEASE PRINT OR TYPE

HEALTH CARE PROVIDER NAME (First, Middle, Last)	**HEALTH CARE PROVIDER STATE LICENSE #:**	**AGENCY USE ONLY**
HEALTH CARE PROVIDER BUSINESS ADDRESS:	**DATE(S) OF SERVICE SPECIFIC TO VIOLATION BEING REPORTED:**	

INJURED EMPLOYEE NAME: (First, Middle, Last)	**DATE OF ACCIDENT:** (mm/dd/yyyy)	**SOCIAL SECURITY #:**

VIOLATION TYPE: **(Check the appropriate violation type. Complete one referral form per violation type reported. A referral form must be submitted for each violation type and must be accompanied by supportive documentation.)**

- ☐ Collected or received payment from injured employee in violation of section 440.13(14)(a), F.S.
- ☐ Failed to follow Standards of Care requirements in accordance with section 440.13(16), F.S., including overutilization of services.
- ☐ Failed to provide medical records and reports pursuant to section 440.13(4)(c), F.S.
- ☐ Failed to refund reimbursement pursuant to section 440.13(11)(a), F.S., for service(s) improperly billed or that constituted overutilization.
- ☐ Improper billing or billing error violation or otherwise failed to comply with the billing and reporting requirements of rule 69L-7.602, F.A.C.

SUPPORTIVE DOCUMENTATION: **(Check the appropriate documentation submitted with the referral form for the alleged violation type)**

- ☐ Explanation of Bill Review (EOBR) for each date of service under review that constitutes an alleged violation for which reimbursement was disallowed or adjusted.
- ☐ Peer Review or IME report(s) supporting the alleged Standards of Care violation, which includes a copy of the Practice Guideline(s) cited as the basis of the alleged violation.
- ☐ Electronic or written correspondence between the provider and insurer regarding: improper billing or billing error(s), failure to provide medical records and reports as requested, and/or failure to refund reimbursement for services improperly billed, billed in error, or constituting over utilization.
- ☐ Copy of letter from the provider or a collection agency directly billing an injured employee or attempting to recover payment on behalf of the provider from an injured employee.
- ☐ Copy of medical bills for date(s) of service under review for an improper billing or a billing error violation.
- ☐ Other (Please Specify):

NAME OF PERSON COMPLETING REFERRAL: **MAILING ADDRESS:** **TELEPHONE: ( ) Ext.** **EMAIL ADDRESS:**	**MAIL REFERRAL FORM AND SUPPORTIVE DOCUMENTATION TO:** **FLORIDA DEPARTMENT OF FINANCIAL SERVICES** **DIVISION OF WORKERS' COMPENSATION** **OFFICE OF MEDICAL SERVICES** **200 EAST GAINES STREET** **TALLAHASSEE, FLORIDA 32399-4232**

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. 817.34. F.S., and s. 440.105(7), F.S.

DWC-2000 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.