



DEPARTMENT OF FINANCIAL SERVICES
Division of Consumer Services – Bureau of Consumer Assistance

MEDICAL PROVIDER REQUEST FOR ASSISTANCE

PLEASE TYPE OR WRITE CLEARLY
and
Follow the Instructions Listed Below:

- ✓ **Please limit additional documentation and only include information, correspondence, or other papers that are instrumental in the processing of your request.**
- ✓ **Please do not submit personal medical records.**
- ✓ **PROVIDE A COPY OF EACH INSURED’S IDENTIFICATION CARD (front and back).**
- ✓ **PROVIDE PROOF OF CLAIM RECEIPT BY INSURER.**
- ✓ **Please submit five (5) claims per company.**

- ✓ **Provide DFS’s Service Request Number, if previously provided**
SR# _____

Insurance Company or HMO (Full Name): _____

Name of the Provider (Group): _____

Provider Contact Person: _____

Provider Complete Mailing Address: _____

Provider Telephone Number: () – –

(1) Name of Insured: _____

Name of Patient: _____

Insured’s Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(2) Name of Insured: _____

Name of Patient: _____

Insured’s Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

Medical Provider Request For Assistance Form (cont'd.)

(3) Name of Insured: _____

Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(4) Name of Insured: _____

Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(5) Name of Insured: _____

Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

Please return completed form(s) to: **Department of Financial Services
Attn: Medical Provider Section
Bureau of Consumer Assistance
200 E. Gaines Street
Tallahassee, FL 32399-0322**