

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: 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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 3. ATTACH AUDIT TAPE.

EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

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

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 2. TOTAL AND ATTACH BILLS IN DATE OF SERVICE ORDER.
 3. ATTACH AUDIT TAPE.

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			