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

☐ INITIAL REPORT SUMMARIZING FIRST SIX MONTHS

☐ ANNUAL REPORT ON OPEN CASE

☐ 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? ☐ 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	
COMPENSATION SETTLEMENT AMOUNT Date Payment Mailed: _____ - _____ - _____	
PENALTIES (Paid to Claimant)	
INTEREST (Paid to Claimant)	

(Amounts entered in paid-to-date columns I & II should not be reduced for recoveries except overpayment recoveries.)

THIRD PARTY RECOVERY AMOUNT: _____

SPECIAL DISABILITY TRUST FUND RECOVERY AMOUNT: _____

ALL OTHER RECOVERIES EXCEPT OVERPAYMENTS: _____

INSURER CODE #	DATE PREPARED: (Month-Day-Year)	INSURER NAME CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
SERVICE CO./TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	

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.

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.