Florida Department of Financial Services
Division of Workers' Compensation, Office of Medical Services
PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE

A Petition for Resolution of Reimbursement Dispute must be served on the Agency within 30 days after the Petitioner's receipt of a notice of disallowance or adjustment of payment, pursuant to 69L-31.008, Florida Administrative Code.

PETITIONER NAME: _____

[MUST BE "Healthcare Provider" as defined in s.440.13(1)(h), Florida Statutes]

PETITIONER MAILING ADDRESS: _____

_____

If the Petition is submitted by an entity acting on behalf of the Petitioner, please provide:

ENTITY NAME: _____

ENTITY MAILING ADDRESS: _____

_____

Name of Injured Employee service(s) provided to: _____

Date(s) of Service Applicable to Petition: _____

1. **Date of receipt of the Explanation of Bill Review (EOBR) from Carrier.** _____
   Select the method Petitioner has used to establish the EOBR date of receipt:
   - ☐ **Date Stamp** (a date stamped EOBR will be accepted as proof of date of receipt by date stamp).
   - ☐ **Verifiable Login Process** (a copy of the applicable portion of the login roster showing the date of login of the EOBR will be accepted as proof of receipt through a verifiable login process).
   - ☐ **Postmark Date** (a copy of the envelope in which the EOBR was sent which clearly and legibly shows the postmark date must accompany the petition).

   If the Petitioner does not establish the date of its receipt of the Explanation of Bill Review by any of the methods set forth in this paragraph, the Petitioner receipt of the EOBR will be deemed to be 5 calendar days from the issue date on the EOBR.

2. **Provide the name, mailing address, and certified mail receipt number for the copy of the Petition served, by United States Postal Service certified mail, on the entity the Carrier designated on the Explanation of Bill Review to receive service of the Petition on behalf of the Carrier and all affected parties. (If the Carrier did not designate on the EOBR the name and mailing address of an entity to receive service of the Petition by certified mail, service of a copy of the petition by certified mail shall be upon the entity that sent the EOBR.)**

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3. **What specific issue(s) form the basis of the Petitioner's dispute of the Carrier's disallowance or adjustment of payment?**

   _____

   _____

   _____

   _____

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4. **What does the Petitioner assert is the correct reimbursement amount for the services that were disallowed or adjusted?**

   $_____ **Attach to the Petition, a detailed calculation of the amount the Petitioner asserts is correct.**

5. **Were the services for which payment was disallowed or adjusted provided pursuant to a reimbursement contract?** _____
   If yes, please provide a copy of the applicable provisions of the reimbursement contract with this Petition.

6. **Did the Petitioner submit all documentation requested in writing by or on behalf of the Carrier with regard to reimbursement for the services in dispute?** _____ **If not, please explain why the requested documentation was not provided.**

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7. Please identify and explain the relevance of any specific document(s) or record(s) provided in support of the allegations made in this petition that the Petitioner would like to particularly call to the attention of the Agency.

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8. Section 440.13(7)(a), Florida Statutes states, " The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a Petitioner to submit such documentation to the agency results in dismissal of the petition."

A petition that is accompanied by all items specified below will not be dismissed for failure to submit all supporting documents and records:

- **Copies of the medical bill or medical bills or requests for reimbursement submitted to the Carrier, which are the subject of this reimbursement dispute.**
- **Copy of each Explanation of Bill Review received from the Carrier which provided notice of disallowance or adjustment of payment in this dispute. If the Explanation of Bill Review does not contain the Petitioner's date stamp establishing date of receipt, documentation of a verifiable login process date of receipt of the EOBR must be submitted.**
- **All medical documentation and records submitted to the Carrier in support of the medical bill or request for reimbursement which is the subject of this dispute.**
- **If the answer to question number 5 above is yes, a copy of all applicable provision(s) of the reimbursement contract.**
- **Provider's documentation of authorization by Carrier for non-emergency treatment for the date(s) of service covered by the Petition.**
- **A detailed calculation of the amount of reimbursement the Petitioner asserts is correct.**
- **Documentation of health care provider notification to the Carrier, pursuant to s.440.13(3)(b), F.S., for emergency treatment for the date(s) of service included in the petiton.**

Signature of Petitioner or other representative authorized to submit the petition on behalf of the Petitioner. **Date**

_____ _____

Please mail the completed Petitition for Resolution of Reimbursement Dispute to:

Division of Workers' Compensation, Office of Medical Services
c/o Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399-4232

Print Form

If additional space is needed to complete your responses to any of the questions, continue on a separate sheet and attach to the form.