DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation - Bureau of Monitoring and Audit

PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE FORM

A Petition for Resolution of Reimbursement Dispute (Petition Form) must be served on the Department within forty-five (45) days after the Petitioner's receipt of a Notice of Disallowance or Adjustment, pursuant to Rule 69L-31.003, Florida Administrative Code (F.A.C.).

PETITIONER NAME: _____ **EMAIL (optional):** _____

[MUST BE "Health Care Provider" as defined in section 440.13(1)(g), Florida Statutes (F.S.)]

MAILING ADDRESS: _____

_____

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

ENTITY NAME: _____ **EMAIL (optional):** _____

MAILING ADDRESS: _____

_____

Name of injured employee the service(s) was provided to: _____

Date(s) of service applicable to petition: _____

1. Date of receipt of the Notice of Disallowance or Adjustment from the Carrier: _____

Select the method used to establish the date of receipt of the Notice of Disallowance or Adjustment:

☐ **Date Stamp** (a date-stamped Notice of Disallowance or Adjustment 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 a date of login of the Notice of Disallowance or Adjustment will be accepted as proof of receipt through a verifiable login process).

☐ **Postmark Date** (a copy of the envelope in which the Notice of Disallowance or Adjustment was sent which clearly and legibly shows the postmark date will be accepted as proof of receipt by postmark date).

If the Petitioner does not establish the date of receipt by any of the methods set forth in this section, the Petitioner's receipt of the Notice of Disallowance or Adjustment will be deemed to be five (5) calendar days from the issue date on the Notice of Disallowance or Adjustment.

2. Provide the name, mailing address, and certified mail receipt number for the copy of the Petition Form served by United States Postal Service certified mail on the entity the Carrier designated on the Notice of Disallowance or Adjustment to receive service of the Petition Form on behalf of the Carrier and all affected parties; or if no such entity was designated by the Carrier, upon the entity that sent the notice.

_____

_____

United States Postal Service certified mail number: _____

3. What does the Petitioner assert is the correct reimbursement amount for the service(s) in dispute that were disallowed or adjusted? $_____

Attach to the Petition Form a detailed calculation of the amount the Petitioner asserts is correct.

4. Was the service(s) for which payment was disallowed or adjusted provided pursuant to a contract? Yes ☐ **No** ☐

If "Yes," and Petitioner is disputing that payment is being made at an amount less than the amount prescribed in such contract, provide the documentation substantiating the contract was in effect for the line item(s) in dispute and provide the provision which governs reimbursement for service(s).

If "Yes," and Petitioner is disputing the applicability of the contract to the line item(s) in dispute, provide documentation substantiating the contract was in effect and the terms of the contract which evidence its inapplicability to the line item(s) in dispute.

If "No," but the services in the Notice of Disallowance or Adjustment were alleged by Carrier as being provided pursuant to a contract and there had been a contract that was no longer in effect for the line item(s) in dispute, provide documentation substantiating that there was no contract in effect for the line item(s) in dispute.

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5. Pursuant to paragraph 69L-7.730(1)(b), F.A.C., at the time of authorization or upon receipt of emergency care, did the claim administrator or entity acting on behalf of the Carrier request in writing supporting documentation?
Yes ☐ No ☐

If "Yes," specify the documentation requested and, in accordance with paragraph 69L-31.003(3)(c), F.A.C., provide a copy of the documentation the Petitioner provided in response to the request.

_____

6. Was the service(s) for which payment was disallowed or adjusted authorized? Yes ☐ No ☐

If "No," was the Providers treatment "Emergency Care"? Yes ☐ No ☐

If authorization was obtained, provide a copy of the authorization.

Section 837.06, F.S., False official statements. – Whoever knowlingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

_____ _____
Signature **Date**

_____ _____
Print Name **Telephone Number**

The Petition Form, accompanied by the supporting documentation outlined in Rule 69L-31.003, F.A.C., must be submitted to the Department by mail or hand delivery to:

DIVISION OF WORKERS' COMPENSATION, MEDICAL SERVICES SECTION
C/O DEPARTMENT OF FINANCIAL SERVICES
200 EAST GAINES STREET
TALLAHASSEE, FLORIDA 32399-4232