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

CARRIER RESPONSE TO PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE FORM

The Carrier Response to Petition for Resolution of Reimbursement Dispute (Response Form) must be filed with the Department within thirty (30) days after receipt of the Petition for Resolution of Reimbursement Dispute Form pursuant to Rule 69L-31.004, Florida Administrative Code (F.A.C.).

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

[MUST BE "Carrier" as defined in section 440.13(1)(c), Florida Statutes (F.S.)]

MAILING ADDRESS: _____

_____

If the Response Form is submitted by an entity acting on behalf of the Carrier, provide:

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

MAILING ADDRESS: _____

_____

PETITIONER NAME: _____

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

Date(s) of service applicable to petition: _____

1. **Provide the name, mailing address, and proof of delivery to the Petitioner (i.e., delivery confirmation) for the copy of the Response Form and all supporting documentation served on the Department in response to the petition.**

   Petitioner Name: _____

   Petitioner Mailing Address: _____

   Proof of Delivery: _____

2. **What does the Carrier assert is the correct reimbursement amount for the service(s) in dispute on the Petition Form? $**_____

   Attach to the Response Form a detailed calculation of the amount the Carrier asserts is the correct reimbursement, a copy of each Notice of Disallowance or Adjustment issued to the Petitioner, and documents supporting the Carrier's disallowance or adjustment.

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

   If "Yes," provide the documentation substantiating the contract was in effect for the line item(s) in dispute and provide the provision which governs reimbursement for medical service(s)/treatment.

4. **Was EOBR Code 10 or 11 used on any line item in dispute to deny payment? Yes ☐ No ☐**

   If "Yes," submit a copy of the Form DFS-F2-DWC-12, Notice of Denial, that was sent to the injured worker and Health Care Provider pursuant to Rule 69L-56.4012, F.A.C.

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

   If "Yes," specify the documentation requested and provide a copy of the documentation received from the Health Care Provider.

   _____

   _____

CARRIER RESPONSE TO PETITION FOR RESOLUTION OF REIMBURSEMENT DISPUTE FORM

6. Was the Petitioner authorized to treat the injured worker for the date(s) of service in dispute? Yes ☐ No ☐

If "No," did the Petitioner submit a request of authorization? Yes ☐ No ☐

If authorization was requested, provide a copy of the Petitioner's authorization request and a copy of the carrier's response.

Signature	**Date**
Print Name	**Telephone Number**

Section 837.06, F.S., False official statements. – Whoever knowingly 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.

The Response Form, accompanied by all supporting documentation, 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