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) PI DATE			TEMPORARY TOTAL From To		
IMPAIRMENT INCOME (D/A On or After 1/1/94) From To			TEMPORARY PARTIAL From To		
WAGE LOSS From To			MEDICAL (PHYSICIAN FEES) From To		
SUPPLEMENTAL INCOME BENEFITS (D/A On or After 1/1/94) From To			HOSPITAL From To		
PERMANENT TOTAL From To			DRUGS, BRACES, PROSTHESIS, OTHER SUPPLIES From To		
PERMANENT TOTAL SUPPLEMENTAL From To			TRAVEL / MILEAGE From To		
LUMP SUM SETTLEMENT (JPO) Date			ATTENDANT CARE From To		
DEATH From To			FUTURE MEDS		
TOTAL PERMANENT COMPENSATION			TOTAL MEDICAL AND TEMPORARY COMPENSATION		
PERIOD FOR WHICH REIMBURSEMENT IS REQUESTED From To			TOTAL PERMANENT, TEMPORARY AND MEDICAL BENEFITS		
TOTAL REIMBURSED PRIOR TO THIS REQUEST $			TOTAL AMOUNT REIMBURSEMENT REQUESTED $		
THIRD PARTY RECOVERIES $					
NAME AND ADDRESS OF PAYEE: PAYEE'S FEDERAL TAX ID# _____			CALCULATIONS/FORMULA		
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:	

FORM DFS-F1-SDF-2 (Rev. 3/09) Rule 69L-10.019, F.A.C.

INSTRUCTIONS: ATTACH APPROPRIATE DOCUMENTATION

1. TT - DWC-4
2. TP - DWC-3
3. WAGE LOSS - DWC-3's
4. PTD PAYSHEET
5. DEATH PAYSHEET
6. PI - DRAFT COPIES AND DWC-4's

NOTE: DWC-3's AND DWC-4's MUST BE FULLY COMPLETED WITH SIGNATURE, DATE PAID AND AMOUNT PAID.

EMPLOYEE'S NAME	
CLAIM NUMBER	DATE OF ACCIDENT

PERIOD	COMPENSATION RATE	TEMPORARY TOTAL	TEMPORARY PARTIAL	WAGE LOSS	PERMANENT TOTAL	DEATH BENEFITS	PERMANENT IMPAIRMENT
TOTALS							

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PAYMENT SCHEDULE A

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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PAYMENT SCHEDULE B

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

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

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PAYMENT SCHEDULE C

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

RX AND MILEAGE			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			

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PAYMENT SCHEDULE D

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

MISCELLANEOUS (PLEASE SPECIFY)			
NAME OF PROVIDER	DATE OF SERVICE	DATE PAID	AMOUNT PAID
TOTALS			

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PAYMENT SCHEDULE E