See Reverse Side of Form for Information Regarding Filing a Grievance

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by: ___Provider ___Injured Worker or a Designated Representative: __ Family Member __ Attorney __ Other
Date of Injury _____

INJURED WORKER'S/ PROVIDER'S NAME: _____
Social Security Number _____
Address:
Home Telephone: _____ Work/Alternate Phone:_____

Contact if other than injured worker or provider_____ Telephone # _____

PRIMARY CARE/TREATING PHYSICIAN: _____
Address: _____
Office Telephone: _____ _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): _____

_____

_____

_____

_____

_____

_____

Has a grievance been previously filed? ___YES___NO IF YES, Date sent? _____

What Action Would You Like to See Taken? _____

_____

_____

_____

_____

_____

Have you received any information regarding your rights and responsibilities under WC Managed Care? Yes ____ No ____

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: _____ _____

Injured Worker/ Provider/ Other — Date Form Completed/Signed

_____ _____

Signature of Grievance Coordinator — Date Grievance Coordinator Signed

MAIL TO: