March 28, 2014

VIA CERTIFIED MAIL

RETURN RECEIPT REQUESTED

rrr\_no

address\_line\_1

address\_line\_2

address\_line\_3

city, state zip\_code

Re: **DEMAND LETTER UNDER FLA. STAT. §627.736(10)**

**NOTICE OF INTENT TO INITIATE LITIGATION**

Provider: medical\_provider

Patient: claimant\_last\_name, claimant\_first\_name claimant\_middle\_name

Date of Loss: date\_of\_loss

Claim No.: claim\_no

Policy No.: policy\_no

Date(s) of Service: dates\_of\_service

Total PIP Billed: total\_billed

PIP Benefits Paid: total\_paid\_predemand

Amount Demanded: amount\_demanded

Postage Cost: $6.13

The undersigned represents the above captioned provider and is providing this demand letter in the form of its Notice of Intent to Initiate Litigation on their behalf. Accordingly, you are respectfully instructed to direct any future communication regarding this claim to our office and to refrain from communicating with the medical provider verbally or in writing. This document is a formal demand letter pursuant to Florida Statute §627.736(10) for the full payment of the amounts listed above. The underlying claim is overdue.

Demand is hereby made for payments of the medical services and treatment provided to the above-named patient for dates of service noted above by the named medical provider. The provider billed the gross total noted above, of which 80% is due less deductible if applicable. Per our mathematical calculations, this figure is noted above as the "Amount Demanded". The medical provider has received the amount noted above, which is not the total amount due for the services rendered and billed.

Please see the enclosed HCFA or itemized billing ledger for a detailed statement of the charges at issue, together with the exact amounts billed for each treatment, the exact dates of each treatment, and the service or accommodations and the type of benefits rendered as identified by the CPT coding.

Additionally, please see the enclosed assignment of benefits provided by the claimant to the medical provider. If the above amounts have been paid or any of the above captioned information is not correct please contact the undersigned, in writing, immediately. Pursuant to Florida Statute § 627.736(10)(c) demand is also hereby made for reimbursement of the above captioned postage cost.

If payment of this amount is made within thirty (30) days of receipt of this letter, said payment must include the applicable interest and 10% penalty of the overdue amount paid, subject to a maximum penalty of $250.00. Payments for benefits and outstanding interest are to be made payable to the named medical provider, and delivered to our law offices. DO NOT SEND THE PAYMENT TO THE PROVIDER. Payments for penalty and postage are to be made payable to the “NAVARRO HERNANDEZ, P.L.”. Failure to issue both payments to these parties, in this form and in full, within 30 days after receipt of this notice will result in litigation. Failure to issue payments, in this form and in full, within 30 days after receipt of this notice will result in litigation. All payments should be mailed to "2151 LeJeune Road, Suite 300, Coral Gables, Florida 33134".

Our office hereby demands, pursuant to Florida Statutes §§ 627.4137, 627.7401, 627.736(4)(b), 627.736(6)(d) and the policy that covers this loss, a statement, under oath, of a corporate officer or the insurer’s claims manager or superintendent setting forth the following information with regard to each known policy of insurance, including excess or umbrella insurance: (A) the name of the insurer; (B) the name of each insured; (C) the limits of liability coverage (including PIP and Med Pay coverage); (D) a statement of any policy or coverage defense which such insurer reasonably believes is available to such insurer at the time of filing such statement; (E) a copy of the policy; and, (F) a copy of the policy declarations page.

Our office also hereby demands a copy of the patient/claimant’s PIP payout sheet and any explanations of benefits generated concerning the above mentioned dates of service, all notices for Independent Medical Exam (“IME”) appointments with proof of mailing, all medical reports done by IME or peer review doctors on behalf of the insurance company, all Examination Under Oath (“EUO”) notices with proof of mailing, EUO transcripts or recordings and all denial letters.

In addition, pursuant to Florida Statutes §§ 627.4137(1)(e) and 627.7401, please consider this a written demand for disclosure of the name and coverage of each known insurer to the claimant and forward this request for information as required by this subsection to all affected insurers.

If the sums claimed in this letter are not paid within thirty (30) days, and/or if a written explanation of benefits is not provided within thirty (30) days, and/or if any of the other information demanded is not provided within thirty (30) days, the named medical provider will be filing a lawsuit against your company.

Thank you for your anticipated cooperation and immediate response to our requests. Should you have any questions, please contact the undersigned.

Very truly yours,

Luis F. Navarro, Esq.

NAVARRO HERNANDEZ, P.L.

Enc.: Medical Bills

Assignment of Benefits

CC: (medical\_provider)