**Fischetti Law Group**

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{{ current\_date\_long }}

**DEMAND LETTER PER FLORIDA STAT. § 627.736(10)**

Via Certified Mail No.: **­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANGELA RINELLA** or designated recipient of 627.736 demand letters

GEICO INDEMNITY COMPANY, GEICO GENERAL INSURANCE COMPANY, GEICO CASUALTY COMPANY

PO BOX 9091

MACON, GA 31208

**PATIENT:** {{ Plaintiff\_full\_name }}

**INSURED:** {{ Defendant\_Insurance\_Co\_insured }}

**PROVIDER:** {{ Clinic\_company\_sk }}

**CLAIM NO.:** {{ Defendant\_Insurance\_Co\_claim\_number }}

**OUR MATTER NO.:** {{ matter\_number }}

**INS. CO.** {{ Defendant\_Insurance\_Co\_company\_sk }}

ITEMIZED STATEMENT –This reflects the dates of service \_\_\_\_\_. The bill is $0. The amount paid is believed to be $0. Please remit payment in the amount claimed to be due and owing of {{ bill\_amount }}**.** If there is a deductible, please let us know. If there is no Med Pay, we are relying on you to tell us prior to any lawsuit. If the amount charged for any service is less than the amount allowed under Fla. Stat 627.736 5 a, then demand is made that Defendant pay 100% of the amount charged for that service. If you have any questions about the bills at issue, please compare the attached ledger to your explanation of benefits which you should have generated and please note we dispute each and every non-payment. If you still have questions or need additional documentation, please let us know. If you respond to this demand letter, we will assume this demand letter is acceptable. If you do not request any additional documentation in response to this demand letter, we will assume you have all the documentation you may need to process the claim and you have waived any request for additional documentation previously made. We are relying on you to tell us if this demand letter, the bills or other documents that were previously submitted were defective in any way before suit is filed. We will assume all defects are waived if you do not inform us in response to this demand letter.

1. Pursuant to Florida Statute, demand is also made for reimbursement of mail and postage costs totaling **$6.59**. Be advised that Florida Statute requires applicable interest and a 10% penalty of the overdue amount. (Maximum of $250.00), be made if the bill is made within thirty (30) days of this receipt of this letter. Failure to make full payment within thirty (30) days will result in filing of a law suit against your company for damages, attorney’s fees and costs.
2. A copy of the assignment of benefits (AOB) is attached. If it is not attached, please let us know within 30 days. If you do not respond by stating, you did not receive the AOB we will assume you have a copy.
3. **The amount listed as currently due is calculated to the best information and belief of the Provider, if the amount listed as “currently due” is incorrect OR the Insurer is in need of any additional information to consider this Demand Letter please advise the undersigned in writing of what specific information is incorrect or needed to process Demand.**
4. STATUTORY INTEREST AND PENALTY PAYMENT AS PERMITTED BY FLORIDA LAW IS HEREBY DEMANDED TO BE MADE PAYABLE TO THE LAW OFFICES OF **Michael J. Fischetti, P.A.,** ONLY
5. DEMAND IS HEREBY MADE FOR: 1) A COPY OF THE UNREDACTED PIP PAYOUT SHEET; 2) EXPLANATION OF BENEFITS FOR EACH BILL NOT PAID OR REDUCED; 3) THE INSURANCE DECLARATION SHEET; 4) **A COPY OF ANY EUO, STATEMENT OR RECORDED TRANSCRIPTS**; 5) A COPY OF ALL IME REPORTS; 6) A COPY OF THE LETTER(S) DEMANDING THE PATIENT TO APPEAR AT AN IME, AN EUO OR A TELEPHONIC RECORDED STATEMENT AND PROOF OF MAIL; 7) AND ANY AND ALL INFORMATION OBTAINED UNDER THE PROVISIONS OF 627.736, AS REQUIRED BY THE PROVISIONS OF 627.736(6)(D) AND 627.4137 FLORIDA STATUTES; 8) Any and all endorsements or policy amendments to the policy made since 1-1-08. If you do not provide these requested documents within thirty (30) days, we may bring suit for declaratory action against you and may seek attorney’s fees and costs.
6. Please make two (2) separate checks, one for the outstanding medical benefits, and a second separate check for the interest, 10% penalty and postage. Our office will not accept any checks with FULL and FINAL language included on either the attorney check or the provider check and they will be refused and returned. Checks with such language will not be considered “payment of demand letter” under 627.736 (10).   **Please make the check for the outstanding medical benefits payable to the above-referenced provider. Please make the interest, penalties and postage check payable to Michael J. Fischetti, P.A., (Tax I.D. 26-4047028).** All checks and documents are to be mailed to **Michael J. Fischetti, P.A.,** within 30 days.
7. Furthermore, it is alleged, and you are put on notice that the Plaintiff shall seek damages as to the Insurance Companies failure to provide an itemized statement (commonly know as an EOB) specifically detailing why the bills at issue in this instant case were denied or reduced
8. Demand is hereby made for the insurer to not exhaust the policy of insurance until after this dispute is resolved. This provider demands payment in full as we do not accept your denials or reductions. Pursuant to F.S. §627.736(6)(f), when it applies, Plaintiff is requesting that the insurer notify Plaintiff when policy limits are reached.  Plaintiff also requests that the insurer notify Michael J. Fischetti, P.A. regarding the same. The insurer must notify Plaintiff, and Michael J. Fischetti, P.A. within 15 days after the limits have been reached.
9. Do not contact the medical provider. Direct all communications regarding this patient and any outstanding bills for other patients to **Michael J. Fischetti, P.A.,** at the address and number above.

Sincerely,

Michael J. Fischetti, Esq.