By Senator Alexander

17-1308A-07

A bill to be entitled

An act relating to motor vehicle liability insurance; amending s. 320.02, F.S.; providing for proof of purchase of medical payments coverage when registering a motor vehicle; conforming a cross-reference; amending ss. 324.021 and 324.022, F.S., relating to financial security requirements for operating a motor vehicle; conforming cross-references; amending s. 627.7275, F.S.; providing that a motor vehicle insurance policy that provides medical payments coverage may not be issued or delivered in this state unless the policy contains specified minimum amounts of coverage for property damage liability arising from a single accident or combined property damage liability and bodily injury liability in any one accident; amending s. 627.7295, F.S.; redefining the term "policy"; authorizing a licensed general lines agent to charge a fee to cover certain administrative costs under certain circumstances; providing an exemption from certain provisions regarding the initial issuance or cancellation of policies containing medical payments coverage and certain other types of liability coverage; conforming a cross-reference; amending s. 627.733, F.S.; deleting a provision requiring the owner or registrant of a taxicab to maintain certain personal injury protection coverage; conforming cross-references; amending s. 627.734, F.S.;

conforming cross-references; amending s. 627.736, F.S.; requiring every insurance policy complying with the security requirements of state law to provide medical payments coverage; identifying types of medical expenses covered by medical payments coverage; limiting coverage for certain medical expenses up to specified amounts per person and per accident; requiring all bills submitted by hospitals and physicians to appear on certain forms; providing for charges and payment for medical services for covered persons; providing definitions; authorizing insurers to negotiate and enter into contracts with preferred providers; providing that only insurers writing motor vehicle liability insurance in this state may provide medical payments coverage benefits; prohibiting an insurer from requiring the purchase of coverage other than property damage liability coverage as a condition for providing such benefits; requiring insurers to make such coverage available through normal marketing channels; providing that failure to make medical payments coverage and property damages liability coverage available through normal marketing channels is a violation of the insurance code; providing penalties; providing for payments of benefits; providing that medical payments coverage benefits are subject to the provisions of the Medicaid program in certain circumstances; requiring each insurer

that has issued a policy providing medical payments coverage to report the renewal, cancellation, or nonrenewal of each policy to the Department of Highway Safety and Motor Vehicles within a specified period after the effective date of each renewal, cancellation, or nonrenewal; requiring each insurer that issues a new policy providing medical payments coverage to report such issuance to the department within a specified period after issuance; providing for the form and contents of such reports; providing that such reports are confidential; limiting the department's use of such reports; providing for the release of certain information regarding insurance coverage upon the written request of specified parties in the event of an automobile accident; requiring a written request for release of information to include a copy of the appropriate accident form; requiring insurers to notify the named insured in writing that any cancellation or nonrenewal of the policy will be reported to the department; requiring that the notice include certain additional information; providing that there is no civil liability due to the insurer's failure to provide such notice; deleting provisions regarding payment of benefits, rights of an insured, charges for treatment of injured persons, billing requirements, disputes, mental and physical examinations of injured persons,

attorney's fees, demand letters, actions for fraud, minimum benefit coverage, and fraud advisory notice; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (a) and (d) of subsection (5) of section 320.02, Florida Statutes, are amended to read:

320.02 Registration required; application for registration; forms.--

(5)(a) Proof that medical payments coverage ~~personal injury protection~~ benefits have been purchased when required under s. 627.733, that property damage liability coverage has been purchased as required under s. 324.022, and that combined bodily liability insurance and property damage liability insurance have been purchased when required under s. 627.7415 shall be provided in the manner prescribed by law by the applicant at the time of application for registration of any motor vehicle owned as defined in s. 627.736(3) ~~s. 627.732~~. The issuing agent shall refuse to issue registration if such proof of purchase is not provided. Insurers shall furnish uniform proof-of-purchase cards in a form prescribed by the department and shall include the name of the insured's insurance company, the coverage identification number, the make, year, and vehicle identification number of the vehicle insured. The card shall contain a statement notifying the applicant of the penalty specified in s. 316.646(4). The card or insurance policy, insurance policy binder, or certificate of insurance or a photocopy of any of these; an affidavit containing the name of the insured's insurance company, the insured's policy number, and the make and year of the vehicle

insured; or such other proof as may be prescribed by the department shall constitute sufficient proof of purchase. If an affidavit is provided as proof, it shall be in substantially the following form:

Under penalty of perjury, I (Name of insured) do hereby certify that I have (Medical Payments Coverage ~~Personal Injury Protection~~, Property Damage Liability, and, when required, Bodily Injury Liability) Insurance currently in effect with (Name of insurance company) under (policy number) covering (make, year, and vehicle identification number of vehicle). (Signature of Insured)

Such affidavit shall include the following warning:

WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A VEHICLE REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER FLORIDA LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT IS SUBJECT TO PROSECUTION.

When an application is made through a licensed motor vehicle dealer as required in s. 319.23, the original or a photostatic copy of such card, insurance policy, insurance policy binder, or certificate of insurance or the original affidavit from the insured shall be forwarded by the dealer to the tax collector of the county or the Department of Highway Safety and Motor Vehicles for processing. By executing the aforesaid affidavit, no licensed motor vehicle dealer will be liable in damages for any inadequacy, insufficiency, or falsification of any statement contained therein. A card shall also indicate

the existence of any bodily injury liability insurance voluntarily purchased.

(d) The verifying of proof of medical payments coverage ~~personal injury protection~~ insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance and the issuance or failure to issue the motor vehicle registration under the provisions of this chapter may not be construed in any court as a warranty of the reliability or accuracy of the evidence of such proof. Neither the department nor any tax collector is liable in damages for any inadequacy, insufficiency, falsification, or unauthorized modification of any item of the proof of medical payments coverage ~~personal injury protection~~ insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance either prior to, during, or subsequent to the verification of the proof. The issuance of a motor vehicle registration does not constitute prima facie evidence or a presumption of insurance coverage.

Section 2. Subsection (1) of section 324.021, Florida Statutes, is amended to read:

324.021 Definitions; minimum insurance required.--The following words and phrases when used in this chapter shall, for the purpose of this chapter, have the meanings respectively ascribed to them in this section, except in those instances where the context clearly indicates a different meaning:

(1) MOTOR VEHICLE.--Every self-propelled vehicle which is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use

with such vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle which is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped. However, the term "motor vehicle" shall not include any motor vehicle as defined in s. 627.736(3) ~~s. 627.732(3)~~ when the owner of such vehicle has complied with the requirements of s. 627.736 ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

Section 3. Section 324.022, Florida Statutes, is amended to read:

324.022 Financial responsibility for property damage.--Every owner or operator of a motor vehicle, which motor vehicle is subject to the requirements of s. 627.736 ~~ss. 627.730-627.7405~~ and required to be registered in this state, shall, by one of the methods established in s. 324.031 or by having a policy that complies with s. 627.7275, establish and maintain the ability to respond in damages for liability on account of accidents arising out of the use of the motor vehicle in the amount of $10,000 because of damage to, or destruction of, property of others in any one crash. The requirements of this section may also be met by having a policy which provides coverage in the amount of at least $30,000 for combined property damage liability and bodily injury liability for any one crash arising out of the use of the motor vehicle. No insurer shall have any duty to defend uncovered claims irrespective of their joinder with covered claims.

Section 4. Subsection (1) of section 627.7275, Florida Statutes, is amended to read:

627.7275 Motor vehicle liability.--

(1) A motor vehicle insurance policy providing medical payments coverage ~~personal injury protection~~ as set forth in s. 627.736 may not be delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or principally garaged in this state unless the policy also provides coverage for property damage liability in the amount of at least $10,000 because of damage to, or destruction of, property of others in any one accident arising out of the use of the motor vehicle or unless the policy provides coverage in the amount of at least $30,000 for combined property damage liability and bodily injury liability in any one accident arising out of the use of the motor vehicle. The policy, as to coverage of property damage liability, must meet the applicable requirements of s. 324.151, subject to the usual policy exclusions that have been approved in policy forms by the office.

Section 5. Paragraph (a) of subsection (1), paragraph (a) of subsection (5), and subsection (7) of section 627.7295, Florida Statutes, are amended to read:

627.7295 Motor vehicle insurance contracts.--

(1) As used in this section, the term:

(a) "Policy" means a motor vehicle insurance policy that provides medical payments coverage ~~personal injury protection~~ and property damage liability coverage.

(5)(a) A licensed general lines agent may charge a per-policy fee not to exceed $10 to cover the administrative costs of the agent associated with selling the motor vehicle insurance policy if the policy covers only medical payments

~~personal injury protection~~ coverage as provided by s. 627.736 and property damage liability coverage as provided by s. 627.7275 and if no other insurance is sold or issued in conjunction with or collateral to the policy. The fee is not considered part of the premium.

(7) A policy of private passenger motor vehicle insurance or a binder for such a policy may be initially issued in this state only if the insurer or agent has collected from the insured an amount equal to 2 months' premium. An insurer, agent, or premium finance company may not directly or indirectly take any action resulting in the insured having paid from the insured's own funds an amount less than the 2 months' premium required by this subsection. This subsection applies without regard to whether the premium is financed by a premium finance company or is paid pursuant to a periodic payment plan of an insurer or an insurance agent. This subsection does not apply if an insured or member of the insured's family is renewing or replacing a policy or a binder for such policy written by the same insurer or a member of the same insurer group. This subsection does not apply to an insurer that issues private passenger motor vehicle coverage primarily to active duty or former military personnel or their dependents. This subsection does not apply if all policy payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer payment plan from the policyholder, provided that the first policy payment is made by cash, cashier's check, check, or a money order. This subsection and subsection (4) do not apply if all policy payments to an insurer are paid pursuant to an automatic electronic funds transfer payment plan from an agent or a managing general agent and if the policy includes, at a

minimum, medical payments coverage ~~personal injury protection~~ pursuant to s. 627.736 ~~ss. 627.730-627.7405~~; motor vehicle property damage liability pursuant to s. 627.7275; and bodily injury liability in at least the amount of $10,000 because of bodily injury to, or death of, one person in any one accident and in the amount of $20,000 because of bodily injury to, or death of, two or more persons in any one accident. This subsection and subsection (4) do not apply if an insured has had a policy in effect for at least 6 months, the insured's agent is terminated by the insurer that issued the policy, and the insured obtains coverage on the policy's renewal date with a new company through the terminated agent.

Section 6. Paragraph (b) of subsection (1) and subsections (3) and (4) of section 627.733, Florida Statutes, are amended to read:

627.733 Required security.--

(1)

(b) Every owner or registrant of a motor vehicle used as a taxicab shall not be governed by paragraph (1)(a) but shall maintain security as required under s. 324.032(1)~~, and s. 627.737 shall not apply to any motor vehicle used as a taxicab~~.

(3) Such security shall be provided:

(a) By an insurance policy delivered or issued for delivery in this state by an authorized or eligible motor vehicle liability insurer which provides the benefits ~~and exemptions~~ contained in s. 627.736 ~~ss. 627.730-627.7405~~. Any policy of insurance represented or sold as providing the security required hereunder shall be deemed to provide insurance for the payment of the required benefits; or

(b) By any other method authorized by s. 324.031(2), (3), or (4) and approved by the Department of Highway Safety and Motor Vehicles as affording security equivalent to that afforded by a policy of insurance or by self-insuring as authorized by s. 768.28(16). The person filing such security shall have all of the obligations and rights of an insurer under s. 627.736 ~~ss. 627.730-627.7405~~.

(4) An owner of a motor vehicle with respect to which security is required by this section who fails to have such security in effect at the time of an accident shall have no immunity from tort liability, but shall be personally liable for the payment of benefits under s. 627.736. With respect to such benefits, such an owner shall have all of the rights and obligations of an insurer under s. 627.736 ~~ss. 627.730-627.7405~~.

Section 7. Section 627.734, Florida Statutes, is amended to read:

627.734 Proof of security; security requirements; penalties.--

(1) The provisions of chapter 324 which pertain to the method of giving and maintaining proof of financial responsibility and which govern and define a motor vehicle liability policy shall apply to filing and maintaining proof of security required by s. 627.736 ~~ss. 627.730-627.7405~~.

(2) Any person who:

(a) Gives information required in a report or otherwise as provided for in s. 627.736 ~~ss. 627.730-627.7405~~, knowing or having reason to believe that such information is false;

(b) Forges or, without authority, signs any evidence of proof of security; or

(c) Files, or offers for filing, any such evidence of proof, knowing or having reason to believe that it is forged or signed without authority,

commits ~~is guilty of~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 8. Section 627.736, Florida Statutes, is amended to read:

627.736 Required medical payments coverage ~~personal injury protection benefits; exclusions; priority; claims~~.--

~~(1) REQUIRED BENEFITS.~~ --Every insurance policy complying with the security requirements of s. 627.733 shall provide medical payments coverage ~~personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(d), to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle~~ as follows:

(1)~~(a)~~ MEDICAL PAYMENTS COVERAGE ~~benefits~~.--Medical expenses incurred for bodily injury caused by an automobile crash for the named insured or the named insured's relatives residing in the same household, a pedestrian injured by any self-propelled vehicle or trailer, or any other person occupying a motor vehicle covered under the policy. Medical expenses up to $25,000 per person or $50,000 per accident for injuries resulting from being struck by an automobile,

involved in an automobile crash, or struck by any other self-propelled vehicle or trailer shall be limited to the provision of:

(a) Transport and treatment rendered by an ambulance provider licensed under part III of chapter 401;

(b) Emergency services and care as defined in s. 395.002 rendered by physicians and hospitals in a hospital emergency department, trauma center, or inpatient department licensed under chapter 395; and

(c) Subsequent medically necessary hospital and physician inpatient care resulting from a motor vehicle crash, if the patient is admitted within 72 hours after the motor vehicle crash. ~~Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies upon spiritual means through prayer alone for healing, in accordance with his or her religious beliefs; however, this sentence does not affect the determination of what other services or procedures are medically necessary.~~

(2) PREFERRED PROVIDER NETWORKS.--An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section. As used in this section, the term "preferred providers" shall include health care providers licensed under chapter 395, chapter 401, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463. An insurer may negotiate and enter into contracts with health insurers for preferred provider networks created

pursuant to s. 627.6471 or workers' compensation insurers for preferred provider networks created pursuant to s. 440.134 to provide the benefits required under this section. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(3) DEFINITIONS.--

(a) "Motor vehicle" means any self-propelled vehicle having four or more wheels which is of a type both designed and required to be licensed for use on the highways of this state and any trailer or semitrailer designed for use with such vehicle.

(b) A "private passenger motor vehicle," means any motor vehicle that is a sedan, station wagon, or jeep-type vehicle, and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type.

(c) A "commercial motor vehicle," means any motor vehicle that is not a motor vehicle used to carry private passengers. The term "motor vehicle" does not include a mobile home or any vehicle used in mass transit other than public school transportation and designed to transport more than five passengers exclusive of the operator of the vehicle, and which is owned by a municipality, a transit authority, or a political subdivision of the state.

(d) "Named insured" means a person, usually the owner of a vehicle, identified in a policy by name as the insured under the policy.

(e) "Owner" means a person who holds the legal title to a motor vehicle, or the debtor or lessee who has the right to possession if a motor vehicle is the subject of a security agreement or lease with an option to purchase.

(f) "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere.

~~(b) Disability benefits. Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.~~

~~(c) Death benefits. Death benefits of $5,000 per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.~~

(4) LIMITATIONS.--Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurers ~~insurer~~ may not ~~shall~~ require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000

be purchased in conjunction with medical payments coverage ~~personal injury protection~~. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates ~~shall be deemed to have violated~~ part IX of chapter 626, and such violation constitutes ~~shall constitute~~ an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance.~~; and~~ Any such insurer committing such violation is ~~shall be~~ subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

(5) BENEFITS.--Benefits due from an insurer pursuant to this section shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under this section. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under this section are subject to the provisions of the Medicaid program.

(6) NOTICES.--

(a) Each insurer that has issued a policy providing medical payments coverage benefits shall report the renewal, cancellation, or nonrenewal thereof to the Department of

Highway Safety and Motor Vehicles within 45 days after the effective date of the renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing medical payments coverage benefits to a named insured not previously insured by the insurer during that calendar year, the insurer shall report the issuance of the new policy to the Department of Highway Safety and Motor Vehicles within 30 days. The report must be in such form and format and contain such information as is required by the department, and must include a format compatible with the data processing capabilities of the department. Failure by an insurer to file proper reports with the department constitutes a violation of the Florida Insurance Code. Reports of cancellations and policy renewals and reports of the issuance of new policies received by the department are confidential and exempt from the provisions of s. 119.07(1). These records shall be used for enforcement and regulatory purposes only, including the generation by the department of data regarding compliance by owners of motor vehicles with financial responsibility coverage requirements. In addition, the department shall release, upon a written request by a person involved in a motor vehicle accident, the name of the person's attorney or of a representative of the person's motor vehicle insurer, the name of the insurance company, and the policy number for the policy covering the vehicle named by the requesting party. The written request must include a copy of the appropriate accident form as provided in s. 316.065, s. 316.066, or s. 316.068.

(b) For each insurance policy providing medical payments coverage benefits, the insurer shall notify the named insured or, in the case of a commercial fleet policy, the first named insured in writing that any cancellation or

nonrenewal of the policy will be reported by the insurer to the department. The notice must also inform the named insured that failure to maintain medical payments coverage and property damage liability insurance on a motor vehicle when required by law may result in the loss of registration and driving privileges in this state, and the notice must inform the named insured of the amount of the reinstatement fees required by s. 627.733(7). This notice is for informational purposes only, and an insurer is not civilly liable for failing to provide this notice.

(c) The department may adopt rules to administer this subsection.

~~(2) AUTHORIZED EXCLUSIONS. Any insurer may exclude benefits:~~

~~(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.~~

~~(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:~~

~~1. Causing injury to himself or herself intentionally; or~~

~~2. Being injured while committing a felony.~~

~~Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits~~

~~pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.~~

~~(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS. No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.~~

~~(4) BENEFITS; WHEN DUE. Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury,~~

~~sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.~~

~~(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.~~

~~(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. However, notwithstanding the fact that written notice has been~~

~~furnished to the insurer, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion by the insurer may be made at any time, including after payment of the claim or after the 30-day time period for payment set forth in this paragraph.~~

~~(c) All overdue payments shall bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest shall be due at the time payment of the overdue claim is made.~~

~~(d) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:~~

~~1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.~~

~~2. Accidental bodily injury sustained outside this state, but within the United States of America or its~~

~~territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.~~

~~3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.~~

~~4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, provided the injured person is not himself or herself:~~

~~a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or~~

~~b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.~~

~~(c) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.~~

~~(f) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.~~

~~(g) Benefits shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or if it is established in a court of competent jurisdiction. Any insurance fraud shall void all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.~~

~~(5) CHARGES FOR TREATMENT OF INJURED PERSONS.~~

~~(a) Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event,~~

~~however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.~~

~~(b)1. An insurer or insured is not required to pay a claim or charges:~~

~~a. Made by a broker or by a person making a claim on behalf of a broker;~~

~~b. For any service or treatment that was not lawful at the time rendered;~~

~~c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;~~

~~d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);~~

~~e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and~~

~~discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good faith effort to do so, as documented in the insurer's file; and~~

~~f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.~~

~~2. Charges for medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, and surface electromyography shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule or other payment methodology established pursuant to s. 440.13.~~

~~3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing when done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 who is also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for~~

~~the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor.~~

~~4. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing that does not meet the requirements of subparagraph 3. shall not exceed the applicable fee schedule or other payment methodology established pursuant to s. 440.13.~~

~~5. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor for the 12-month period ending June 30 of that year, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the Accreditation Association for Ambulatory Health Care, the American College of Radiology, or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for~~

~~the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor for the 12-month period ending June 30 of that year. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395.~~

~~6. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The initial list shall be adopted by January 1, 2004, and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and shall not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.~~

~~(c)1. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient~~

~~services rendered at a hospital owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.~~

~~2. If, however, the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35 day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:~~

~~a. A denial letter from the incorrect insurer; or~~

~~b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.~~

~~3. For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph; and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Health Care Finance Administration.~~

~~4. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:~~

~~BILLING REQUIREMENTS. Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the~~

~~statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.~~

~~(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD 9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may include~~

~~charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.~~

~~(c)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:~~

~~a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;~~

~~b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;~~

~~c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;~~

~~d. That the physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and~~

~~e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain~~

~~percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.~~

~~2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.~~

~~3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.~~

~~4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.~~

~~5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.~~

~~6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.~~

~~7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form that shall be used to fulfill the requirements of this paragraph, effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form~~

~~of its own which otherwise complies with the requirements of this paragraph.~~

~~8. As used in this paragraph, "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.~~

~~9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.~~

~~(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, then the insurer shall~~

~~pay to the person 40 percent of the amount of the reduction, up to $500.~~

~~(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.~~

~~(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.~~

~~(a) Every employer shall, if a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, furnish forthwith, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.~~

~~(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce~~

~~forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.~~

~~(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section, the insurer~~

~~may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.~~

~~(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.~~

~~(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.~~

~~(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.~~

~~(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides,~~

~~or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health~~

~~professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.~~

~~(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and~~

~~obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.~~

~~(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES. With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 shall apply, except as provided in subsection (11).~~

~~(9)(a) Each insurer which has issued a policy providing personal injury protection benefits shall report the renewal, cancellation, or nonrenewal thereof to the Department of Highway Safety and Motor Vehicles within 45 days from the effective date of the renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing personal injury protection benefits to a named insured not previously insured by the insurer thereof during that calendar year, the insurer shall report the issuance of the new policy to the Department of Highway Safety and Motor Vehicles within 30 days. The report shall be in such form and format and contain such information as may be required by the Department of Highway Safety and Motor Vehicles which shall include a format compatible with the data processing capabilities of said department, and the Department of Highway Safety and Motor Vehicles is authorized to adopt rules necessary with respect~~

~~thereto. Failure by an insurer to file proper reports with the Department of Highway Safety and Motor Vehicles as required by this subsection or rules adopted with respect to the requirements of this subsection constitutes a violation of the Florida Insurance Code. Reports of cancellations and policy renewals and reports of the issuance of new policies received by the Department of Highway Safety and Motor Vehicles are confidential and exempt from the provisions of s. 119.07(1). These records are to be used for enforcement and regulatory purposes only, including the generation by the department of data regarding compliance by owners of motor vehicles with financial responsibility coverage requirements. In addition, the Department of Highway Safety and Motor Vehicles shall release, upon a written request by a person involved in a motor vehicle accident, by the person's attorney, or by a representative of the person's motor vehicle insurer, the name of the insurance company and the policy number for the policy covering the vehicle named by the requesting party. The written request must include a copy of the appropriate accident form as provided in s. 316.065, s. 316.066, or s. 316.068.~~

~~(b) Every insurer with respect to each insurance policy providing personal injury protection benefits shall notify the named insured or in the case of a commercial fleet policy, the first named insured in writing that any cancellation or nonrenewal of the policy will be reported by the insurer to the Department of Highway Safety and Motor Vehicles. The notice shall also inform the named insured that failure to maintain personal injury protection and property damage liability insurance on a motor vehicle when required by law may result in the loss of registration and driving~~

~~privileges in this state, and the notice shall inform the named insured of the amount of the reinstatement fees required by s. 627.733(7). This notice is for informational purposes only, and no civil liability shall attach to an insurer due to failure to provide this notice.~~

~~(10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.~~

~~(11) DEMAND LETTER.~~

~~(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).~~

~~(b) The notice required shall state that it is a "demand letter under s. 627.736(11)" and shall state with specificity:~~

~~1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.~~

~~2. The claim number or policy number upon which such claim was originally submitted to the insurer.~~

~~3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.~~

~~(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs~~

~~shall be reimbursed by the insurer if so requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.~~

~~(d) If, within 15 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 15 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty shall not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to~~

~~payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer shall not be obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.~~

~~(c) The applicable statute of limitation for an action under this section shall be tolled for a period of 15 business days by the mailing of the notice required by this subsection.~~

~~(f) Any insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.~~

~~(12) CIVIL ACTION FOR INSURANCE FRAUD. An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.~~

~~(13) MINIMUM BENEFIT COVERAGE. If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.~~

~~(14) FRAUD ADVISORY NOTICE. Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:~~

~~(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.~~

~~(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.~~

Section 9. This act shall take effect July 1, 2007.

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SENATE SUMMARY

Provides for the proof of purchase of medical payments coverage. Provides that a motor vehicle insurance policy providing medical payments coverage may not be issued or delivered in this state unless the policy contains specified minimum amounts of certain types of liability coverage. Authorizes a licensed general lines agent to charge a fee not to exceed $10 to cover certain administrative costs under certain circumstances. Provides an exemption to certain provisions regarding the initial issuance or cancellation of policies containing medical payments coverage and certain other types of liability coverage. Requires every insurance policy complying with the security requirements of state law to provide medical payments coverage. Identifies types of medical expenses covered by medical payments coverage. Limits coverage for certain medical expenses up to specified amounts per person and per accident. Requires all bills submitted by hospitals and physicians to appear on certain forms. Provides for charges and payment for medical services for covered persons. Authorizes insurers to negotiate and enter into contracts with preferred providers. Provides that only insurers writing motor vehicle liability insurance in this state may provide medical payments coverage benefits. Prohibits an insurer from requiring the purchase of coverage other than property damage liability coverage as a condition for providing such benefits. Requires insurers to make such coverage available through normal marketing channels. Provides that failure to make medical payments coverage and property damages liability coverage available through normal marketing channels is a violation of the insurance code. Provides penalties. Provides for payments of benefits. Provides that medical payments coverage benefits are subject to the provisions of the Medicaid program in certain circumstances. Requires each insurer that has issued a policy providing medical payments coverage to report the renewal, cancellation, or nonrenewal of each policy to the Department of Highway Safety and Motor Vehicles within a specified period after the effective date of each renewal, cancellation, or nonrenewal. Requires each insurer that issues a new policy providing medical payments coverage to report such issuance to the department within a specified period after issuance. Provides for the form and contents of such reports. Provides that such reports are confidential. Limits the department's use of such reports. Provides for the release of certain information regarding insurance coverage upon the written request of specified parties in the event of an automobile accident. Requires a written request for release of information to include a copy of the appropriate accident form. Requires insurers to notify the named insured in writing that any cancellation or nonrenewal of the policy will be reported to the department. Requires that the notice include certain additional information. Provides that no civil liability attaches due to the insurer's failure to provide such notice.