

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.

For Drug Products - Complete sections 1, 2 & 4 For Supplies & Equipment - Complete sections 1, 3 & 4

SECTION I

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)			2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #		
3. DATE OF ACCIDENT	4. EMPLOYEE'S DOB	5. GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. CLAIMS-HANDLING ENTITY INTERNAL FILE #	
7. INSURER/CARRIER NAME & ADDRESS			8. EMPLOYER'S NAME & ADDRESS		

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)		10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE \$
14. RX # new <input type="checkbox"/> refill <input type="checkbox"/>	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME		17b. FL. DOH LICENSE #
9. NDC# (5-4-2 format)		10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE \$
14. RX # new <input type="checkbox"/> refill <input type="checkbox"/>	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME		17b. FL. DOH LICENSE #
9. NDC# (5-4-2 format)		10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE \$
14. RX # new <input type="checkbox"/> refill <input type="checkbox"/>	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME		17b. FL. DOH LICENSE #

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY		19a. PURCHASE DATE		20. USUAL CHARGE \$
		19b. RENTAL DATE		
21. HCPCS CODE	22. QUANTITY		23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #
18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY		19a. PURCHASE DATE		20. USUAL CHARGE \$
		19b. RENTAL DATE		
21. HCPCS CODE	22. QUANTITY		23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

SECTION 4

24. NAME OF PHARMACY OR MEDICAL SUPPLIER		25. REMITTANCE RECIPIENT'S FEIN #	
26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER		27. REMITTANCE ADDRESS (if different from Field 26.) Check if Same <input type="checkbox"/>	
28. NAME OF PHARMACIST OR MEDICAL SUPPLIER		29. PHARMACIST'S DOH LICENSE #/ MED. SUPPLIER'S LICENSE #	

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2 \$	31. TOTAL REIMBURSEMENT FROM SECTION 3 \$
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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR 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.

COMPLETION INSTRUCTIONS – FORM DFS-F5-DWC-10

SECTION 1 – Field 1 thru Field 8 required to be completed by Pharmacy and Medical Equipment and Supply providers:

1. Employee's Name – Enter the injured employee's name: First, Middle Initial, if applicable, and Last.
2. Employee's Social Security # or Division-Assigned # – Enter the injured employee's social security or division-assigned number. Contact the insurer/carrier to obtain the division-assigned identification number if unknown and if there is no known social security number.
3. Date of Accident – Enter the date of accident, injury or illness, for which services are rendered, in MM/DD/CCYY format.
4. Employee's DOB – Enter the injured employee's date of birth in MM/DD/CCYY format.
5. Gender – Enter the injured employee's gender by checking one box: "Male" or "Female".
6. Claims-Handling Entity Internal File # – Enter the number assigned to the claim file by the insurer/carrier.
7. Insurer/Carrier Name & Address – Enter the name, address and zip code of the insurer/carrier. If self-insured, enter "self-insured".
8. Employer's Name & Address – Enter the name, address, and zip code of the injured worker's employer on the date of accident entered in Field 3.

SECTION 2 - Field 9 thru Field 17 required to be completed for pharmaceutical products ONLY when dispensed from a pharmacy:

9. NDC# - Enter the National Drug Code number segmented into the universal 5-4-2 format or enter the unique workers' compensation code COMPD000000-0000963-0074 if the prescription dispensed is compounded by the pharmacist and not commercially available.
10. Quantity – Use common billing unit language by entering the number of billing units, AND, one of the following three billing unit descriptors: "each", "ml", or "gm". Do not enter dosage forms or package descriptions such as tablet, capsule or kit.
11. Days – Enter the estimated number of days the medication will last according to prescription's dosage and administration instructions.
12. Medication & Strength – Enter the complete medication/drug name and dosage strength, as dispensed.
13. Usual Charge – Enter the pharmacy's usual charge for the drug. When Field 15 is coded "2" enter the pharmacy's usual charge for the generic equivalent.
14. RX # – Enter the provider's internal number assigned to the prescription, if applicable, and check one box, as applicable: "new" or "refill" prescription.
15. DAW Code – Enter one of the following "Dispense as Written" codes, as appropriate.
 - 0 = No product selection indicated
 - 1 = Substitution not allowed by provider
 - 2 = Substitution allowed- patient requested product dispensed
 - 3 = Substitution allowed- pharmacist selected product dispensed
 - 4 = Substitution allowed- generic drug not in stock
 - 5 = Substitution allowed- brand drug dispensed as generic
 - 6 = Override
 - 7 = Substitution not allowed- brand drug mandated by law
 - 8 = Substitution allowed- generic drug not available in marketplace
 - 9 = Other
16. Date Filled – Enter the date the prescription is filled in MM/DD/CCYY format.
- 17a. Prescriber's Name – Enter the name of the ordering health care provider.
- 17b. FL DOH License # – Enter the ordering health care provider's license number, as assigned by the Florida Department of Health. For Out of State health care providers, enter ZZ999999999999.

SECTION 3 – Field 18 thru Field 23 required to be completed for medical equipment and supplies ONLY when dispensed by a pharmacy or medical supplier:

18. Description of Medical Equipment or Supply – Enter the name or description of the item(s) dispensed.
- 19a. Purchase Date – Enter the date of purchase in MM/DD/CCYY format. Leave blank if the item is provided pursuant to a rental agreement.
- 19b. Rental Date – Enter the start date of the rental period and the end date of the rental period following the word “To”. Enter both dates in MM/DD/CCYY format. Leave blank if the item is purchased.
20. Usual Charge - Enter the provider’s usual charge for the item(s) purchased. Enter the provider’s usual monthly rental charge for an item when reporting a Rental Date in Field 19b.
21. HCPCS Code – Enter the HCPCS (CPT level II) code for the item(s).
22. Quantity – Enter the quantity and the size, when applicable.
- 23a. Prescriber’s Name - Enter the name of the ordering health care provider.
- 23b. FL DOH License # – Enter the ordering health care provider’s license number as assigned by the Florida Department of Health. For Out of State health care providers, enter ZZ999999999999.

SECTION 4 – Field 24 thru Field 289 required to be completed by Pharmacy and Medical Equipment and Supply providers. ~~Field 29 required to be completed by Pharmacy providers.~~

24. Name of Pharmacy or Medical Supplier - Enter the provider’s business name.
25. Remittance Recipient’s FEIN # – Enter the Federal Employer Identification Number (FEIN) of the pharmacy, medical supplier or entity acting on behalf of the pharmacy, medical supplier, carrier or insurer for the purpose of receiving payment from the carrier/insurer.
26. Physical Address of Pharmacy or Medical Supplier – Enter the address where the pharmacy or supplier is physically located, including street address, city, state and zip code.
27. Remittance Address – Enter the mailing address where the insurer/carrier is instructed to send reimbursement for items included on this statement or check the “Same” box if remittance should be sent to the physical address entered in Field 26.
28. Name of Pharmacist or Medical Supplier – Enter the name of the person that rendered the billable medication or medical supply.
29. Pharmacist’s Florida Department of Health License #/Med. Supplier’s License # – Enter the pharmacist’s ~~provider’s~~ license number as assigned by the Florida Department of Health. For Out of State pharmacists, enter ZZ999999999999. Providers of Medical Equipment and Supplies- Enter the alpha characters ‘DME’ followed by the license number assigned by the Florida Agency for Health Care Administration.

FOR INSURER/CARRIER USE - Field 30 and/or Field 31 required to be completed by Insurer/Carriers, as applicable.

30. Total Reimbursement from Section 2 – Insurer/Carrier to enter the total dollar amount the insurer/carrier reimbursed to the entity identified by the FEIN number in Field 25 for items in Section 2.
31. Total Reimbursement from Section 3 – Insurer/Carrier to enter the total dollar amount the insurer/carrier reimbursed to the entity identified by the FEIN number in Field 25 for items in Section 3.