



DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

DFS-F5-DWC-90 (UB-04) - B Completion Instructions

Hospitals shall complete the DFS-F5-DWC-90 (UB-04) according to the Field Attributes and Notes, pursuant to the National Uniform Billing Committee Official UB-04 Data Specifications Manual 20089 (UB-04 Manual), ~~September~~ July 2008, and the procedure specifications shown below.

| Form Locator | Data Element | Procedure Specific for Florida Workers' Compensation |
|--------------|---|--|
| 1 | Provider Name, Address and Telephone Number | Required. Enter the provider's name, physical address (including zip code) where the service(s) being billed were provided and a valid telephone number. |
| 2 | Pay-to Name and Address | Enter the name and address where the provider listed in form locator 1 expects payment to be made. |
| 3a | Patient Control Number | Pursuant to the UB-04 Manual. |
| 3b | Medical/Health Record Number | Pursuant to the UB-04 Manual. |
| 4 | Type of Bill | Pursuant to UB-04 Manual |
| 5 | Federal Tax Number | Pursuant to the UB-04 Manual. |
| 6 | Statement Covers Period | Pursuant to the UB-04 Manual. |
| 7 | Reserved for Assignment by NUBC | Pursuant to the UB-04 Manual. |
| 8a | Patient Name/Identifier | Required. Enter patient's social security number or Division assigned number. |
| 8b | Patient Name/Identifier | Required. Enter patient's name: last, first, middle initial, if applicable. |
| 9 | Patient Address | Pursuant to the UB-04 Manual. |
| 10 | Patient Birth date | Pursuant to the UB-04 Manual. |
| 11 | Patient Sex | Pursuant to the UB-04 Manual. |
| 12 | Admission/Start of Care Date | Required. Pursuant to the UB-04 Manual. |
| 13 | Admission Hour | Pursuant to the UB-04 Manual. |
| 14 | Priority (Type) of Visit | Pursuant to the UB-04 Manual. |
| 15 | Source of Referral for Admission or Visit | Pursuant to the UB-04 Manual. |
| 16 | Discharge Hour | Pursuant to the UB-04 Manual. |
| 17 | Patient Discharge Status | Pursuant to the UB-04 Manual. |
| 18-28 | Condition Codes | Required. Enter code 02 and all other applicable codes. |
| 29 | Accident State | Pursuant to the UB-04 Manual. |
| 30 | Reserved for Assignment by NUBC | Pursuant to the UB-04 Manual. |
| 31 | Occurrence Codes and Dates | Required. Enter code "04" and enter the date of the accident/injury/illness as MMDDYY. |
| 32-34 | Occurrence Codes and Dates | Pursuant to the UB-04 Manual. |
| 35-36 | Occurrence Span Codes and Dates | Pursuant to the UB-04 Manual. |
| 37 | Reserved for Assignment by NUBC | Pursuant to the UB-04 Manual. |
| 38 | Responsible Party Name and Address | Required. Enter identify <u>Identify the name and mailing address of the workers' compensation insurer identified in form locator 50 (party responsible for non-compensable charges.</u> Must enter name, address and zip code. |
| 39-40 | Value Codes and Amounts | Pursuant to the UB-04 Manual. |
| 42 | Revenue Code | Pursuant to the UB-04 Manual. |
| 43 | Revenue Description | Pursuant to the UB-04 Manual. |
| 44 | HCPCS/Rates/HIPPS Rate Codes | Required, pursuant to the UB-04 Manual. CPT, HCPCS, or workers' compensation unique code(s) and modifier(s) required for all outpatient bills. |
| 45 | Service Date | Pursuant to the UB-04 Manual. |
| 46 | Service Units | Pursuant to the UB-04 Manual. |



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| 47 | Total Charges | Required. Total of all billed charges. |
| 48 | Non-covered Charges | Pursuant to the UB-04 Manual. |
| 49 | Reserved for Assignment by NUBC | Blank. |
| 50 | Payor Name | Required. Enter the name, address and zip code for the Workers' Compensation insurer/carrier. Pursuant to the UB-04 Manual. |
| 51 | Health Plan Identification Number | Pursuant to the UB-04 Manual. |
| 52 | Release of Information Certification Indicator | Pursuant to the UB-04 Manual. |
| 53 | Assignment of Benefits Certification Indicator | Pursuant to the UB-04 Manual. |
| 54 | Prior Payments - Payor | Pursuant to the UB-04 Manual. |
| 55 | Estimated Amount Due - Payor | Pursuant to the UB-04 Manual. |
| 56 | National Provider Identifier - Billing Provider | Required, pursuant to the UB-04 Manual. Enter the NPI Number of the facility where the service was provided. |
| 57 | Other Provider Identifier | Pursuant to the UB-04 Manual. |
| 58 | Insured's Name | Pursuant to the UB-04 Manual. |
| 59 | Patient's Relationship to the Insured | Pursuant to the UB-04 Manual. |
| 60 | Insured's Unique Identification | Pursuant to the UB-04 Manual. |
| 61a | (Insured) Group Name | Pursuant to the UB-04 Manual. |
| 62 | Insurance Group Number | Pursuant to the UB-04 Manual. |
| 63 | Treatment Authorization Code | Pursuant to the UB-04 Manual. |
| 64 | Document Control Number (DCN) | Pursuant to the UB-04 Manual. |
| 65 | Employer Name (of the Insured) | Required. Enter the name and address for the injured workers' employer at the time of onset for the accident/injury/illness (the date entered in FL 31). |
| 66 | Diagnosis and Procedure Code Qualifier (ICD Version Indicator) | Pursuant to the UB-04 Manual. |
| 67 | Principal Diagnosis Code | Pursuant to the UB-04 Manual. |
| 67A-Q | Other Diagnoses Codes | Pursuant to the UB-04 Manual. |
| 68 | Reserved for Assignment by NUBC | Blank. |
| 69 | Admitting Diagnosis | Pursuant to the UB-04 Manual. |
| 70a-c | Patient's Reason for Visit | Pursuant to the UB-04 Manual. |
| 71 | Prospective Payment System (PPS) Code | Not Required. |
| 72a-c | External Cause of Injury (ECI) Code | Pursuant to the UB-04 Manual. |
| 73 | Reserved for Assignment by NUBC | Blank. |
| 74 | Principal Procedure Code and Date | Pursuant to the UB-04 Manual. |
| 74a-e | Other Procedure Codes and Dates | Pursuant to the UB-04 Manual. |
| 75 | Reserved for Assignment by NUBC | Blank. |
| 76 | Attending Provider Name and Identifiers | Required. Enter the attending provider's name (Last, First) below the block labeled 'Attending'; Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of-State, enter the provider's license number issued by the licensing entity in that state. |



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| 77 | Operating Physician Name and Identifiers | Situational. Enter the operating provider's name (Last, First) after the block labeled 'Operating'; Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of-State, enter the provider's license number issued by the licensing entity in that state. |
| 78-79 | Other Provider Name and Identifiers | Pursuant to the UB-04 Manual. |
| 80 | Remarks Field | Required Entry - ALL OUTPATIENT SURGERY OR SURGICAL SERVICE(S) BILLS : must enter "scheduled" or "non-scheduled" surgical status. Required Entry - ALL SURGICAL BILLS CHARGING FOR- INPATIENT IMPLANTS-CERTIFICATIONS : must enter the word "Implants(s)" followed by <u>the</u> reimbursement <u>amount</u> calculated made pursuant to rule 69L-7.501, F.A.C. |
| 81 | Code - Code Field | Not Required |