

Form DFS-F5-DWC-11 - B

Completion Instructions

Submitted by Licensed Dentists

A. Header Information – Fields 1 and 2

1. Type of Transaction: Enter an 'x' in the box indicating "Statement of Actual Services".
2. Predetermination/Preauthorization Number: Optional for completion. May enter the insurer/carrier's prior authorization number.

B. Insurance Company/Dental Benefits Plan Information - Field 3

3. Company/Plan Name, Address, City, State, Zip Code: Enter the name, address, and zip code of the workers' compensation insurer/carrier.

C. Other Coverage – Fields 4-11

4. Other Dental or Medical Coverage: No entry required.
5. Name of Policyholder/Subscriber in #4: No entry required.
6. Date of Birth: No entry required.
7. Gender: No entry required.
8. Policyholder/Subscriber ID (SSN or ID#): Enter the injured employee's social security number or division-assigned number. If there is no known social security number or if the division-assigned number is unknown, the health care provider must contact the insurer/carrier to obtain the number.
9. Plan/Group Number: No entry required.
10. Patient's Relationship to Person Named in #5: No entry required.
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: No entry required.

D. Policyholder/Subscriber Information – Fields 12-17

12. Policyholder/Subscriber Name, Address, City, State, Zip Code: Enter the name, address, and zip code of the employer of the injured employee on the date entered in Field 46.
13. Date of Birth: No entry required.
14. Gender: No entry required.
15. Policyholder/Subscriber Identifier: No entry required.
16. Plan/Group Number: No entry required.
17. Employer Name: No entry required.

E. Patient Information – Fields 18-23

18. Relationship to Policyholder/Subscriber in #12 Above: No entry required.
19. Student Status: No entry required.

20. Name, Address, City, State, Zip Code: Enter the injured employee's last name, first name and middle initial, if applicable.
21. Date of Birth: Enter the injured employee's date of birth in MM/DD/CCYY format.
22. Gender: Enter the injured employee's gender by entering an 'x' in one box: "M" = male or "F" = female.
23. Patient ID/Account #: Optional. The injured employee's account number, as recorded in the health care provider's accounting system may be entered for additional injured employee identification.

F. Record of Services Provided – Fields 24-33

24. Procedure Date: Enter the date of service in MM/DD/CCYY format. If multiple dates are involved, e.g. root canal therapy and prosthesis enter the preparation date/impression date/opening date of canal and the completion or seating date.
25. Area of Oral Cavity: No entry required.
26. Tooth System: No entry required.
27. Tooth Number(s) or Letter(s): Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen ("-") to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Tooth Surface: Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B = Buccal; D= Distal; F = Facial; L = Lingual; M = Mesial; and O = Occlusal.
29. Procedure Code: Enter the valid CDT, CPT[®], NDC or unique workers' compensation procedure code.
30. Description: Enter the description of the service rendered.
31. Fee: Enter the health care provider's usual charge, in dollar and cent format, for the procedure reported on each line when a procedure code is entered in Field 29. Do not use special characters, i.e., dollar signs (\$) or decimal points (.) when reporting charges. If multiple units are billed, enter the total charge by multiplying the units of service times the charge per unit.
32. Other Fee(s): No entry required.
33. Total Fee: Enter the total of all charges listed in Field 31 in dollar and cent format. Enter the total of all charges listed in Field 31 using dollar and cent format. Do not use special characters, i.e., dollar signs (\$) or decimal points (.) when reporting charges. Total each page separately if multiple Form DFS-F5-DWC-11 (ADA Dental Claim Form) claim forms are submitted for the same injured employee for the same date of service.

G. Missing Teeth Information – Fields 34 and 35

- 34. (Place an 'x' on each missing tooth): Mark the appropriate alpha and/or numeric box for each tooth that is missing.
- 35. Remarks: List any unusual service.

H. Authorizations – Fields 36 and 37

- 36. The injured employee or his/her authorized representative must sign and date this field or the signature must be on file with the health care provider to permit the release of any medical or other information necessary to process the claim. If the signature is on file, enter the words "Signature on File" or "SOF". If the injured employee's representative signs, the relationship to the injured employee must be indicated. When an illiterate or physically handicapped employee signs by mark (x), a witness must sign his/her name and enter his/her address next to the mark.
- 37. No entry required.

I. Ancillary Claim/Treatment Information – Fields 38-47

- 38. Place of Treatment: Enter an "x" in the appropriate box to indicate the place of treatment: "Provider's Office", "Hospital", "ECF" or "Other".
- 39. Number of Enclosures: Enter the number of radiographs, oral images or models, as applicable.
- 40. Is Treatment for Orthodontics?: Enter an "x" in the appropriate box: "No" or "Yes". If "No" is entered, skip Fields 41-42. If "Yes" is entered, complete Fields 41-42.
- 41. Date Appliance Placed: If Field 40 is checked "Yes", enter the date in MM/DD/CCYY format.
- 42. Months of Treatment Remaining: Enter the total number of months remaining to complete treatment, if applicable.
- 43. Replacement of Prosthesis: Enter an "x" in the appropriate box: "No" or "Yes".
- 44. Date Prior Placement: Enter the date in MM/DD/CCYY format, if yes is checked in Field 43.
- 45. Treatment Resulting from: Enter an "x" in the appropriate box(es): "Occupational Illness/Injury" if the billed services are for a condition covered by workers' compensation insurance, "Auto Accident" if the billed services are for a condition related to an automobile accident, "Other Accident" if the billed services are for a condition related to any type of accident other than an automobile accident or employment.
- 46. Date of Accident: Enter the date of the work related accident, injury or illness in MM/DD/CCYY format.
- 47. Auto Accident State: No entry required.

J. Billing Dentist or Dental Entity – Fields 48-52A

- 48. Name, Address, City, State, Zip Code: Enter the name, address and zip code of the health care provider or entity to which is payment is due.
- 49. NPI: No entry required.
- 50. License Number: No entry required.
- 51. SSN or TIN: Enter the federal tax identification number of the dentist or entity to which payment is to be rendered. The entry will be either a Social Security Number or a Tax Identification Number.
- 52. Phone Number: No entry required.
- 52A. Additional Provider ID: No entry required.

K. Treating Dentist and Treatment Location Information – Fields 53-58

- 53. Enter the name of the dentist who rendered the direct billable services. THE DENTIST'S NAME AND LICENSE NUMBER (FIELD 55) MUST AGREE.
- 54. NPI: No entry required.
- 55. License Number: Enter the dentist's alpha-numeric license number as assigned by the Florida Department of Health. For Out of State dentist's, enter the license number assigned by the licensing entity for that state.
- 56. Address, City, State, Zip Code: Enter the name, address, and zip code of the physical location where the dentist rendered the direct billable service(s).
- 56A. Provider Specialty Code: No entry required.
- 57. Phone Number: Enter the telephone number including the area code of the dentist that rendered direct billable service.
- 58. Additional Provider ID: No entry required.