Form DFS-F5-DWC-9 – B

Completion Instructions

Submitted by Licensed Health Care Providers

A. Header Information

Health Care Providers shall enter Insurer/Carrier name, address and zip code in the blank area on top-right side of the form.

B. Fields 1-33

1. Types of health insurance coverage: No entry required.

1a. Insured's I.D. Number: Enter the injured employee's social security number or division-assigned number. If there is no known social security number and the division-assigned number is unknown, the health care provider must contact the insurer/carrier to obtain the number.

2. Patient's Name: Enter the name of the injured employee: last name, first name and middle initial, if applicable.
3. Patient's Birth Date: Enter the injured employee's date of birth in MM/DD/YY format. Sex: Enter an "x" in the appropriate box to indicate injured employee's sex: M = male; F = female
4. Insured's Name: Enter the business name for the injured employee's employer on the date entered in Field 14.
5. Patient's Address: Enter the injured employee's complete mailing address and telephone number in the appropriate spaces:
   Line 1 - Enter the street address, including apartment number if applicable;
   Line 2 - Enter the city and state;
   Line 3 - Enter the zip code and telephone number including area code.
6. Patient Relationship to Insured: No entry required.
7. Insured's Address: Enter the complete business address of the employer entered in Field 4:
   Line 1 - Enter the street address, including suite number if applicable;
   Line 2 - Enter the city and state;
   Line 3 - Enter the zip code and telephone number, including area code.
8. Patient Status: No entry required.
9. Other Insured's Name: No entry required.
   a. Other Insured's Policy or Group Number: Optional. May enter the insurer's claim number.

b.Other Insured's Date of Birth and Sex: No entry required.
c. Employer's Name or School Name: No entry required.
d. Insurance Plan Name or Program Name: Optional. May enter the workers' compensation insurer/carrier's telephone number including area code.

10. Is Patient's Condition Related To:
    a. Employment? Enter an "x" in the appropriate box to indicate whether any of the billed services are for a condition covered by workers' compensation insurance.
    b. Auto Accident? Enter an "x" in the appropriate box to indicate whether any of the billed services are for a condition related to an automobile accident.
    c. Other Accident? Enter an "x" in the appropriate box to indicate whether any of the billed services are for a condition related to any type of accident other than an automobile accident or employment.

10d. Reserved for Local Use: Enter the word "ATTACHMENT" if the claim form is accompanied by attachment(s) (e.g. documentation of supply costs, medical records, etc.).

11. Insured's Policy Group or FECA Number: No entry required.
    a. Insured's Date of Birth: No entry required.
    b. Employer's Name or School Name: No entry required.
    c. Insurance Plan Name or Program Name: No entry required.
    d. Is There Another Health Benefit Plan?: No entry required.
12. Patient's or Authorized Person's Signature: 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.
13. Insured's or Authorized Person's Signature: No entry required.
14. Date of Current Illness or Injury or Pregnancy: Enter the date of onset, in MM/DD/YY, i.e. date of first symptom or current accident, illness or injury.
15. If Patient Has Had Same or Similar Illness: Enter the date in MM/DD/YY format, if the injured employee reports or experienced symptoms same as or similar to those for the illness or injury for which the claim is submitted.
16. Dates Patient Unable to Work in Current Occupation: No entry required.

17. Name of Referring Provider or Other Source: Enter the complete name of the referring physician.
17a. Enter the Florida Department of Health alpha-numeric license number of the referring health care provider, if available.
17b. NPI: No entry required.
18. Hospitalization Dates Related to Current Services: Enter "FROM" and "TO" dates, in MM/DD/YY format, when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19. Reserved for Local Use: No entry required.
20. Outside Lab? / Charges: No entry required.
21. Diagnosis or Nature of Illness or Injury: Enter the ICD-9-CM diagnosis code. (Include the decimal point in the ICD-9-CM code, as applicable.) When more than one diagnosis is identified and multiple ICD-9-CM codes are used, the code representing the primary diagnosis **must be listed FIRST** in Field 21(1). Additional diagnosis codes (ICD-9-CM) may be entered in Fields 21(2), 21(3) and/or 21(4).
22. Medicaid Resubmission Code: No entry required.
23. Prior Authorization Number: Optional for completion. May enter the insurer/carrier's prior authorization number.
24. Claim Detail Lines: In Fields 24A, 24B, 24C, 24D, 24E, 24F, and 24G enter the specific information for the services provided. All characters in all sections of a detail line should be within the given fields. Refer to Rule Chapter 69L-7.602(4)(b), F.A.C. for special billing instructions. Do not use special characters, e.g. dashes (-), dollar signs ($), decimal points (.), etc.
    A. Date(s) of Services: Enter the "FROM" and "TO" date of service in MM/DD/YY format. Multiple dates of service may be billed on a single line ONLY if the dates of service are consecutive and occur within the same month. For example: April 30, May 1, 2, and 3, 2004
       Line 1=043004
       Line 2=050104 050304
       If only a single date is applicable, enter the same date in the "FROM" and "TO" fields.
    B. Place of Service: Enter the appropriate 2-digit numeric place of service code as identified in the Current Procedural Terminology (CPT) Manual.
    C. EMG: Enter a "Y" for yes or "N" for no in this field to indicate if the procedure was performed as an emergency.

D. Procedures, Services, Supplies: Enter the valid CPT, CDT, HCPCS, NDC or unique workers' compensation procedure code in the first section of Field 24D (under CPT/HCPCS). Enter COMPD if the prescription dispensed is compounded by the physician and
not commercially available. Enter the 2-character modifier, if required and when appropriate, in the second section of Field 24D (under MODIFIER). See Rule 69L-7.602(4)(b), F.A.C., special billing instructions for anesthesia services. NOTE: THE CARRIER MUST NOT CHANGE OR MARK THROUGH THE ORIGINAL PROCEDURE CODE OR MODIFIER AS ENTERED BY THE HEALTH CARE PROVIDER.

E. Diagnosis Pointer: Enter from Field 21, the diagnosis(es) reference number(s) (1, 2, 3 and/or 4) to relate the date of service and procedures performed to the appropriate diagnosis. Up to four reference codes may be entered for each procedure code, as appropriate, i.e. 1, 2, 3, 4.

F. $ Charges: 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 24D. If multiple units are billed, enter the total charge by multiplying the units of service times the charge per unit. NOTE: THE CARRIER MUST NOT CHANGE OR MARK THROUGH THE CHARGE AMOUNT ENTERED BY THE HEALTH CARE PROVIDER.

G. Days or Units: Enter whole numbers in Field 24G to represent the total number of days, hours, units, quantity of drug, supply or service rendered. Total anesthesia time must be reported in minutes. See Rule 69L-.602(4)(b), F.A.C., for special billing instructions for anesthesia services, pharmaceuticals and medical supplies.

H. EPSDT Family Plan: No entry required.

I. ID. Qual: No entry required.

J. Rendering Provider ID. #: No entry required.

25. Federal Tax I.D. Number: Enter the tax identification number of the health care provider or entity to which payment is due. Enter an "x" in the appropriate box to indicate if the number is a Federal Employer Identification Number (FEIN) or a social security number (SSN). Do not use special characters, e.g. periods (.), dashes (-), etc.
26. Patient's Account No.: 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.

27. Accept Assignment?: No entry required.
28. Total Charge: Enter the total of all charges listed in Field(s) 24F 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-9 (CMS-1500) claim forms are submitted for the same injured employee for the same date of service.
29. Amount Paid: No entry required.
30. Balance Due: No entry required.
31. Signature of Physician or Supplier Including Degrees or Credentials: Enter the name of the health care provider who rendered the direct billable services. THE HEALTH CARE PROVIDER'S NAME AND PERSONAL IDENTIFICATION NUMBER (FIELD 33 b) MUST AGREE.
32. Service Facility Location Information: Enter the zip code of the physical location where services were rendered.
    a. No entry required.
    b. No entry required.
33. Billing Provider Info & Ph #: Enter the name, address and zip code of the health care provider or entity to which payment is due.
    a. No entry required.
    b. All treatment, care and attendance services are to be billed by the recognized health care provider who directly rendered the billable service(see Rule 69L-7.602(4)(b)(3) for special billing instructions for recognized practitioners who are salaried employees of an authorized treating physician). Enter the health care provider's alpha-numeric Florida Department of Health license number or unique license number format specifications are as follows:
    - Independent Laboratories enter "IL" for required alpha characters followed by the number "8" and a maximum of 10 additional numeric characters (i.e. IL8##########).
    - Advanced Registered Nurse Practitioners enter "ARNP" for required alpha characters followed by a maximum of 9 numeric characters (i.e. ARNP#########
    - Radiology and Other Facilities (providing only the technical component) enter "XX" for required alpha characters and 99999999999 for required numeric characters (i.e.XX99999999999).