

Form DFS-F5-DWC-9 - A

Completion Instructions

Submitted by Work Hardening and Pain Management Programs

A. Header Information

1. 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.
 - a. Insured's ID 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 Date of Birth: Enter month, day and year of injured employee's date of birth.

Patient's Sex: Enter an "x" in the appropriate box to indicate injured employee's sex.
4. Insured's Name: Enter the employer's business name.
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.
 - d. 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 month, day and year format, 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 month, day and year 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: Enter "FROM" and "TO" dates, in month, day and year format, if the injured employee is unable to perform in his/her usual occupation.
17. Name of Referring Physician or Other Source: Enter the complete name of the referring physician or insurer/carrier.
 - a. ID Number of Referring Physician: Enter the Florida Department of Health alpha-numeric license number of the referring physician, if available.
18. Hospitalization Dates Related to Current Services: Enter "FROM" and "TO" dates, in month, day and year 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: No entry required.
21. Diagnosis or Nature of Illness or Injury: Enter the ICD-9-CM diagnosis code.

(Include decimal 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. Enter the insurer/carrier's prior authorization number.

24. Claim Detail Lines: In Fields 24A, 24B, 24C, 24D, 24E, 24F, 24G, and 24K enter the specific information for the services provided. All characters in all sections of a detail line should be within the given fields. Do not use special characters, e.g. dashes (-), dollar signs (\$), decimal points (.), etc.

A. Dates of Services: Enter the "FROM" and "TO" dates of service in month, day and year format. Multiple dates of service may be billed on a single line 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 2-digit numeric place of service, "99", for all dates of service.

C. Type of Service: Enter 01 for telephone contact, 02 for written correspondence or 03 for personal contact.

D. Procedures, Services, or 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 the 2-digit modifier, if required and when appropriate, in the second section of Field 24D (under MODIFIER). Do not enter modifiers in

the third section. Leave blank. NOTE: THE CARRIER MUST NOT CHANGE OR MARK THROUGH THE ORIGINAL PROCEDURE CODE OR MODIFIER AS ENTERED BY THE HEALTH CARE PROVIDER.

- E. Diagnosis Code: Enter from Field 21, the diagnosis(es) reference numbers (1, 2, 3 and/or 4) to relate the date of service and procedure performed to the appropriate diagnosis. Up to four reference numbers 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 the numbers in Field 24G to represent the total number of units of services/supplies rendered. Enter all units of service that specify time in hours and quarter hours. For example, if the time required was two hours and fifteen minutes, the entry on the claim form would be 2.25 units; one hour would be entered as 1 unit, etc.
- H. EPSDT Family Plan: No entry required.
- I. EMG (Emergency): Enter a "Y" for yes or "N" for no in this field to indicate if the procedure was performed as an emergency.
- J. COB: No entry required.
- K. Reserved for Local Use: FOR INSURER/CARRIER/SELF-INSURED USE ONLY
NOTE: HEALTH CARE PROVIDERS MUST NOT ENTER ANY INFORMATION IN THIS FIELD.

25. Federal Tax ID Number: Enter the tax identification number of the 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. If multiple Form DFS-F5-DWC-9 (CMS-1500) claim forms are submitted for the same injured employee, total each page separately.
- 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 interdisciplinary team leader.
- 32. Name and Address of Facility Where Services Were Rendered: Enter the zip code of the physical location where services were rendered.
- 33. Physician's, Supplier's Billing Name, Address, Zip Code & Phone #: Enter the name, address, zip code and telephone number of the billing entity to which payment is due.

PIN#: Enter "WC" for the required alpha characters followed by the qualified rehabilitation provider's number (to a maximum of 10 numeric characters), as assigned by the Florida Department of Education, Bureau of Rehabilitation & Re-employment immediately after "PIN#":

WC1##### for Individual Qualified Rehabilitation Providers (QRPs), or

WC2##### for Rehabilitation Facilities, or

WC3##### for Rehabilitation Companies (Some Individual QRPs are employed by and bill through Rehabilitation Companies.)