

*Florida*

# **Medical EDI Implementation Guide (MEIG)**

**2007**

for

**Electronic Medical Report Submission**



**Department of Financial Services  
Division of Workers' Compensation  
Office of Data Quality and Collection  
Medical Data Management Section**

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## Definitions

**Accepted Claim:** Any medical claim that is acknowledged by the division as complete and accurate, passing all edits, and successfully loaded into the division's database

**Claim Detail Record(s):** Record or records that contain specific information: services, charges, quantities, etc., reported on the claim, and associating the specific information to the claim header record

**Claim Header Record:** A record that contains unique identifying information about a submitted medical claim

**Data Element:** A single field within a physical record, e.g., date of accident, procedure code, etc.

**Defective Transmission:** A transmission that could not be processed by the division due to structural failures, e.g., empty file, invalid file name, etc.

**Division Forms: Includes the following for medical data reporting forms**

Form DFS-F5-DWC-9, (CMS-1500) Health Insurance Claim Form

Form DFS-F5-DWC-10, Statement of Charges for Drugs and Medical Supplies Form

Form DFS-F5-DWC-11, American Dental Association Dental Claim Form (Rev. 2006)

Form DFS-F5-DWC-90, (UB-04 CMS-1450), Uniform Bill (Hospital Billing Claim Form)

**Electronic Data Interchange (EDI):** Computer to computer exchange of business transactions in a standardized format

**File Layout:** A file description specifying the data elements by name, field type, field size, field position, location within a record, and other applicable requirements, establishing the order in which data for each record must be transmitted

**Medical Claim Processing Report (ASCII Data File):** A computer-readable report containing the results of the processing of all the claims submitted in a transmission that is electronically placed in a submitter's SSL/FTP account for retrieval

**Medical Claim Processing Report (PDF Report):** A human-readable report containing the results of the processing of all the claims submitted in a transmission that is electronically placed in a submitter's SSL/FTP account for retrieval

**New Submitter Specifications:** The document required by the division prior to the first submission of electronic data that contains submitter contact information and other specifications

**Production Transmission:** An electronic file containing required data elements from designated forms sent to the division after the submitter has received division approval to transmit data electronically

## Definitions

**Rejected Claim:** Any medical claim that is acknowledged by the division as incomplete and/or inaccurate, failing system or business edits, not successfully loaded into the division's database, and returned to the submitter for correction and re-filing

**Report:** Any form related to medical services rendered, in relation to a workers' compensation injury, which is required to be filed with the division

**Report Reason Code:** An indicator in the claim header record specifying that the submitted claim is an original report, a withdrawal of a previously submitted report, a correction to a previously rejected report, or a replacement of a previously accepted report

**SSL/FTP:** An internet-based file transfer protocol with a Secure Socket Layer (SSL) that provides data encryption, client and/or server authentication, and message integrity, using a Public Key Infrastructure (PKI) system based on digital certificates

**Submitter:** An insurer, service company/TPA, entity or any other party acting as an agent or vendor on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the division

**Submitter ID:** A unique number assigned by the division to identify a submitter

**Test Transmission:** A sample electronic file containing the required data elements from designated division forms for the purpose of evaluation by the division to ensure the submitter's accuracy and program compatibility with division standards and edits, prior to the transmission of production data

**Transmission Header Record (HD1):** A single record at the beginning of each transmission that has information regarding the transmission, e.g., submitter ID, form type, revision code, etc.

**Transmission ID:** A sequentially assigned number for each transmission (formerly called VolSer Number)

**Transmission Receipt Confirmation:** An e-mail notice sent to the submitter to verify that the transmission has been received by the division

**Transmission Trailer Record (TR1):** A single record at the end of each transmission that contains the total claim count for the transmission

# **Submitter Responsibilities**

## **Obtaining a Submitter ID**

A submitter must complete and submit to the division the New Submitter Specifications document for assignment of a Submitter ID prior to transmittal of the first electronic submission. This document is found on page 78 of this guide.

Each submitter will receive only one Submitter ID. All transmissions received by the division must contain claims with the same Submitter ID in the control numbers as reported in the transmission header.

## **Submitting a Submitter Client List**

A submitter must provide the division with an accurate and complete list of insurers and/or service co/TPAs for whom they will be transmitting electronic data. This list must include the insurer's code number and, if applicable, the service co/TPA's code number (both assigned by the division), full name, federal employer identification number (FEIN), and office location zip code. It is the responsibility of the submitter to notify the division when any insurer or service co/TPA is added to or deleted from the client list, to avoid claim rejection when transmissions are processed. The Submitter Client Listing Update Request Form on page 80 is used for this notification.

## **Establishing an SSL/FTP Account**

An SSL/FTP account shall be established for transmitting electronic medical transactions to the division. Instructions for setting up an SSL/FTP account can be downloaded from the division's website at [www.fldfs.com/wc](http://www.fldfs.com/wc) or can be obtained by contacting the Medical Data Management Section in the Office of Data Quality and Collection at 850.413.1607.

## **Submitting Test Transmissions**

Prior to submission of production data to the division, each submitter must provide a test transmission for each form type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90). The division will review and analyze the test transmission to ensure the accuracy of the data being transmitted and program compatibility with division standards outlined in the section entitled "DWC Form File Layouts" beginning on page 10 of this guide. Instructions for the test transmission are found in the "Test Transmission Guidelines" section on page 5 of this guide.

## **Test Transmission Guidelines**

Before a submitter can be approved to submit production data to the division, the submitter must send a test transmission to the division for each form type being filed. This test transmission is reviewed and analyzed to ensure the data are formatted in accordance with the standards detailed in the “DWC Form File Layouts” section beginning on page 10 of this guide and in accordance with s. 440.13(4) and s. 440.185(5), Florida Statutes. (See Appendix J for proper file naming formats.)

### **Test Transmission Content**

For each of the four form types (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, or DFS-F5-DWC-90), data in the test transmission must match the data shown on 15 paper claim forms. Test transmissions must be sent via SSL/FTP.

Test files must incorporate scenario testing that the Medical Data Management team deems necessary, dependent upon the format revision.

### **Requirements for Test Transmission of Paper Claim Forms**

A copy of the paper claim forms matching the 15 electronically transmitted reports must accompany the test transmission and be sorted in the order they appear on the transmission. Failure to properly sort paper claim forms could result in a delay in processing the test transmission.

### **Test Transmission Processing Address**

The test transmission paper claim forms may be sent to the division at the following address:

**Florida Department of Financial Services**

**Division of Workers' Compensation**

**Office of Data Quality and Collection**

**Attn: Medical Data Management Section**

**200 E. Gaines Street**

**Tallahassee, Florida 32399-4226**

The test transmission paper claim forms may also be faxed to (850) 921-0305.

### **Test Transmission Approval**

If the test transmission meets division requirements for approval, the submitter will be notified in writing, by e-mail, of the date electronic submission of production data may begin.

### **Test Transmission Rejection**

If the test transmission fails to meet requirements for approval, the submitter will be notified in writing, by e-mail, as to the reasons for the rejection. The division will retain the copies of the submitted paper claim forms for use when the submitter resubmits the test transmission for review.

***NOTE: Data used in a test transmission are NOT considered “filed with the division”. The filing requirement of the originally received claim form from the provider must be met pursuant to Rule 69L-7.602 (5)(e), F.A.C., by submitting the data again in production.***

# Production Transmission Guidelines

## Types of Transmissions Effective November 1, 2004

Beginning November 1, 2004, all submitters shall submit data using only the SSL/FTP transmission method.

The submitter will be notified via e-mail if the data transmission cannot be processed, and the transmission will be placed in the “badfiles” folder on their SSL/FTP account. Data are not considered “filed with the division” until the submitter submits a replacement transmission that is successfully accepted into the division’s database. (Refer to Appendix J for proper file naming formats.)

## Sequencing of Records in Transmissions:

All transmissions must be submitted with records in the following order:

Transmission Header Record (HD1)  
Claim #1 Header Record  
Claim #1 Detail Record #1  
Claim #1 Detail Record #2  
Claim #1 Detail Record #3 (actual number of detail records for each claim varies)  
Claim #2 Header Record  
Claim #2 Detail Record #1  
Claim #2 Detail Record #2  
Claim #3 Header Record  
Claim #3 Detail Record #1  
Claim #3 Detail Record #2  
Claim #3 Detail Record #3  
Claim #3 Detail Record #4  
Transmission Trailer Record (TR1)

***NOTE: Only one set of HD1/TR1 records is allowed for each transmission file. When transmitting all four form types on a monthly basis, it will be necessary to transmit four separate transmission files each month (one for each form type).***

## Submitting a Previously Reported Disallowed or Denied Line Item

If one or more line item(s) are disallowed or denied for a claim, these line items must be submitted to the division with the entire claim using the appropriate EOBR codes found in Appendix E and reporting the disallowed or denied charges as \$0.00. If and when the disallowed or denied line item(s) are resubmitted by the provider and paid or adjusted and paid, they must be reported to the division as a new bill with new unique control numbers.

## **Division Processing of Data Transmissions**

Each data transmission received is processed through a data quality program specific to the claim form type. Each claim is validated and analyzed. Once the transmission has been processed through the data quality programs, Medical Claim Processing Reports are generated. These reports will be placed in the outgoing folder on the division's SSL/FTP account for the submitter to retrieve as notification of the division's acceptance or rejection of the medical report data submitted. The layout for this division-generated report can be found beginning on page 57 of this guide.

### **Division's Acceptance / Rejection of Claims**

Submitted claims containing no errors in any data elements will be accepted by the Medical Data Management System. Submitted claims containing errors in any data element will be rejected by the system. Upon completion of processing the submitted file, a Medical Claim Processing Report will be placed, in two formats (PDF and text file), in the "outgoing" folder of the submitter's SSL/FTP mailbox. The submitter will be notified via e-mail when the reports are completed and available for pickup. The PDF version summarizes the number of claims submitted, accepted, and rejected in the transmission. This report also lists each claim submitted, its status as accepted or rejected, and the reason(s) for rejection. The TXT version contains the same information as the PDF file in a machine readable fixed-column format (see page 57 for file layout).

After receiving this report, the submitter shall verify that all of the data in the transmission have been accurately accounted for on the report and investigate any errors. All rejected claims must then be re-submitted with necessary corrections, using the same control number as the original rejected claim(s) to the division. The original submission and the re-submission of rejected claims must be in compliance with Rule 69L-7.602 (5)(e), F.A.C. Data are not considered "filed with the division" until they have been submitted with no errors and accepted into the medical database.

### **Division's Outstanding Rejection Reports**

Twice each month, the division will generate an Outstanding Rejection Report, which will be placed, in two formats (PDF and text file), in the "outgoing" folder on the SSL/FTP server for pick up by batch submitters. This report is comprised of cumulative unresolved rejection issues and serves as a reminder of the corrections that need to be made. Rejections that have not been corrected and successfully accepted into the division's database are not considered "filed with the division" and are subject to penalty pursuant to Rule 69L-7.602 (7) Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, F.A.C.

***NOTE: When submitting a correction for a rejected claim, a replacement claim, or a withdrawal claim, use the same control number that was used in the original submission of the claim.***

## Annual Data Closeout

The division has established a policy for closing out medical claims data for a given calendar year. On June 30 of each year, medical claims with the previous calendar year's dates of service will be "frozen" to create a stable, final version of the data set for the previous calendar year. This final version will be used for analysis in creating new fee schedule information, resolving medical disputes, and conducting research into medical trends in workers' compensation. Submitters need to keep this annual deadline in mind and make sure that as many submissions, corrections, replacements, and withdrawals as possible that are related to the previous calendar year are processed by June 30.

After June 30 of each year, medical claims submitted with dates of service during the previous calendar year will continue to be processed by the system; however, they will be internally flagged to indicate they were received after the official cut-off deadline for closeout, and they will not be included in the formal baseline data set for the previous calendar year. This process will be transparent to the submitter, but the important concept is for submitters to strive to get all claims related to the previous calendar year into the Medical Data Management System database by June 30, so that the data will be included in the closeout.

Please note that this closeout requirement does not negate the timely filing requirement as established in Rule 69L-7.602, F.A.C.

***NOTE: For an individual claim with multiple dates of service, the claim's earliest date of service is used to establish the date of service for the entire claim.***

**DFS-F5-DWC**

**FORM FILE**

**LAYOUTS**

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**TRANSMISSION HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Valid Value = 09
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_  (‘_’ indicates 1 space)	<u>REQUIRED</u> Valid Value = D_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<u>REQUIRED</u> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to Date Insurer Paid, Adjusted, Disallowed or Denied Bill
9H			38-300	263	SPACE FILLER FORMAT: Space fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER  FORMAT: SSSYYJJNNNNN SSS= SUBMITTER ID YY=Year submitted JJJ= Julian date of day submitted NNNNN = Sequence number	<b><u>REQUIRED</u></b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG  FORMAT: N	<b><u>REQUIRED</u></b> Valid Value = 1
3A			15-16	2 Num	FORM ID  FORMAT: NN	<b><u>REQUIRED</u></b> Valid Value = 09
4A			17-21	5 Num	INSURER CODE NUMBER  FORMAT: NNNNN	<b><u>REQUIRED</u></b> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 – 06999
5A			22-30	9 Num	INSURER FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<b><u>REQUIRED</u></b> Must be numeric
6A			31-39	9 Num	INSURER LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)  *Location is the insurer’s office responsible for report	<b><u>REQUIRED</u></b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300  
CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7A			40-44	5 Num	SERVICE CO/TPA CODE NUMBER  FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill
8A			45-53	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present)
9A			54-62	9 Num	SERVICE CO/TPA LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (* '_' indicates 1 space)  *Location is the Service Co/TPA's office responsible for report	<u>SITUATIONAL</u> Must be numeric Left justify and space fill until end of field 1 <sup>st</sup> four digits must not equal '0000' Must be a valid 5 or 9 digit Zip Code If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present)
10A	1a	INSURED'S ID NUMBER	63-71	9 Num	EMPLOYEE IDENTIFICATION NUMBER  (For a division-assigned number go to the division's web site at <a href="http://www.fldfs.com/wc/organization/odqc.html">http://www.fldfs.com/wc/organization/odqc.html</a> )  FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be SSN or Division-Assigned Number Division-Assigned Number must begin with '0000'
11A	14	DATE OF CURRENT ILLNESS/ INJURY/ PREGNANCY	72-79	8 Date	DATE OF ACCIDENT, ILLNESS OR INJURY  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be less than or equal to "Date of Service – From" and "Date of Service - To"

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
12A	2	PATIENT'S NAME	80-109	30 A/N	INJURED EMPLOYEE'S LAST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
13A	2	PATIENT'S NAME	110-124	15 A/N	INJURED EMPLOYEE'S FIRST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
14A	2	PATIENT'S NAME	125	1 Alpha	INJURED EMPLOYEE'S MIDDLE INITIAL FORMAT: A OR _ (‘ _ ’ indicates 1 space)	<b>SITUATIONAL</b> Must be uppercase A-Z If not applicable, space fill
15A	3	PATIENT'S BIRTH DATE *	126-133	8 Date	INJURED EMPLOYEE'S DATE OF BIRTH FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day *Or as reported on DFS-F5-DWC-1	<b>REQUIRED</b> Must be valid date in the correct format Must be less than or equal to “Date of Accident”
16A	3	SEX	134	1 Alpha	INJURED EMPLOYEE'S GENDER FORMAT: A	<b>REQUIRED</b> F = Female, M = Male, U = Unknown
17A	33b	BILLING PROVIDER INFO & PH #	135-147	13 A/N	PROVIDER'S FLORIDA LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN (See Appendix F for valid formats)	<b>REQUIRED</b> Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
18A	25	FEDERAL TAX ID NUMBER	148-156	9 Num	PROVIDER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
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**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
19A	32	SERVICE FACILITY LOCATION INFORMATION	157-165	9 Num	ZIP CODE WHERE SERVICES WERE RENDERED FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
20A			166-173	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service - To”
21A			174-181	8 Date	DATE INSURER PAID, ADJUSTED, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider”
22A	29	AMOUNT PAID	182-192	11 Num	TOTAL PAID TO PROVIDER OR REIMBURSED TO INJURED EMPLOYEE BY INSURER FORMAT: NNNNNNNNNNN	<b>REQUIRED</b> Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field
23A			193-194	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	<b>REQUIRED</b> Must be numeric Must be a valid value
24A			195-196	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	<b>SITUATIONAL</b> 1 <sup>st</sup> position must be alpha 2 <sup>nd</sup> position must be numeric If field 31A equals “E”, space fill
25A	21 <sub>1</sub>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	197-204	8 A/N	ICD-9 DIAGNOSTIC CODE 1 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>REQUIRED</b> Must be a valid ICD-9 code Left justify and space fill to end of field

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
26A	21 <sub>2</sub>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	205-212	8 A/N	ICD-9 DIAGNOSTIC CODE 2 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill
27A	21 <sub>3</sub>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	213-220	8 A/N	ICD-9 DIAGNOSTIC CODE 3 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill
28A	21 <sub>4</sub>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	221-228	8 A/N	ICD-9 DIAGNOSTIC CODE 4 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill
29A			229-258	30 /N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER  (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field
30A			259-278	20 /N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
31A			279	1 Alpha	PRE-PAYMNT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted, Disallowed or Denied Bill” is before the “Date of Service – From” due to an agreement between the provider and the insurer, place a “P” in this field If the Employee has been directly reimbursed by the insurer, place an “E” in this field If none of the above are applicable, space fill
32A			280	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)**  
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**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
33A			281-300	20	SPACE FILLER FORMAT: Space Fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	<b>REQUIRED</b> Must be numeric NNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	<b>REQUIRED</b> Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	<b>REQUIRED</b> NNN Valid Values = 001-999 Must be numeric Left pad with zeros to fill all 3 digits (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	24B	PLACE OF SERVICE	18-19	2 Num	PLACE OF SERVICE FORMAT: NN  (See the AMA’s CPT manual for valid values)	<b>REQUIRED</b> Must be numeric Must be a valid code
5B	24E	DIAGNOSIS POINTER	20-23	4 Num	ICD-9 DIAGNOSTIC CODE REFERENCE NUMBER (S) FORMAT: N_ _ _ OR NN_ _ OR NNN_ OR NNNN  (‘_’ indicates space)	<b>REQUIRED.</b> Must be numeric Left justify and space fill to end of field Must correlate with appropriate ICD-9 Code shown in header fields 25A, 26A, 27A, 28A Valid Values: 1, 2, 3, 4, or any combination of these must be keyed in place of the corresponding diagnosis(es) in Form Fields ID 21 <sub>1</sub> , 21 <sub>2</sub> , 21 <sub>3</sub> , 21 <sub>4</sub>
6B	24D	PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	24-28	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY PROVIDER) FORMAT: NNNNN, OR ANNNN	<b>REQUIRED</b> Must be a valid CPT, HCPCS or Unique Florida WC code

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
7B	24D	PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	29-30	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 1 (AS BILLED BY PROVIDER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
8B	24D	PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	31-32	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 2 (AS BILLED BY PROVIDER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
9B	24D	PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	33-34	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 3 (AS BILLED BY PROVIDER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
10B	24D	PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	35-36	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 4 (AS BILLED BY PROVIDER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
11B			37-41	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS PAID BY INSURER)  FORMAT: NNNNN, OR ANNNN	<u>REQUIRED</u> Must be a valid CPT, HCPCS or Unique Florida WC code If an NDC number is present, submit code 96370 and report the NDC number in field 21B
12B			42-43	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 1 (AS PAID BY INSURER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fills

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
13B			44-45	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 2 (AS PAID BY INSURER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
14B			46-47	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 3 (AS PAID BY INSURER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
15B			48-49	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER 4 (AS PAID BY INSURER)  FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
16B	24F	\$ CHARGES	50-60	11 Num	PROVIDER CHARGE PER LINE  FORMAT: NNNNNNNNNNN	<u>REQUIRED</u> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
17B	24G	DAYS OR UNITS	61-63	3 Num	NUMBER OF DAYS, HOURS, MINUTES OR UNITS*  FORMAT: NNN  *Anesthesia units must be reported in total minutes	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field Must be whole number Must not equal all zeros
18B			64-74	11 Num	INSURER PAYMENT TO PROVIDER OR REIMBURSED TO INJURED EMPLOYEE PER LINE*  FORMAT: NNNNNNNNNNN  *After all adjustments have been applied	<u>REQUIRED</u> Must be numeric Decimal point implied at 2 places Right justify and zero pad on the left to complete field

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300  
CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
19B	24A	DATE(S) OF SERVICE FROM	75-82	8 Date	DATE OF SERVICE – FROM FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b><u>REQUIRED</u></b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date of Service – To” Must be less than or equal to “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”, unless the Pre-Pay indicator = P
20B	24A	DATE(S) OF SERVICE TO	83-90	8 Date	DATE OF SERVICE – TO FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b><u>REQUIRED</u></b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service – From”
21B			91-103	13 A/N	NATIONAL DRUG CODE NUMBER (5-4-2 FORMAT)  FORMAT: NNNNN-NNNN-NN or Space Fill WHERE NNNNN = Manufacturer Code NNNN = Product Code NN = Package Code	<b><u>SITUATIONAL</u></b>  <b><u>REQUIRED</u></b> If 11B = “96370”  Must be a valid NDC number Must be numeric Dashes must be in positions 6 and 11, as indicated Right justify and zero pad on the left (all segments)  <b><u>OTHERWISE</u></b> If 11B is not equal to “96370” Space fill
22B			104-105	2 Num	EXPLANATION OF BILL REVIEW CODE 1  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>REQUIRED</u></b> Must be valid code
23B			106-107	2 Num	EXPLANATION OF BILL REVIEW CODE 2  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>SITUATIONAL</u></b> Must be valid code If not applicable, space fill

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300  
CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
24B			108-109	2 Num	EXPLANATION OF BILL REVIEW CODE 3 FORMAT: NN  (See Appendix E for valid EOBR Codes)	<u>SITUATIONAL</u> Must be valid code If not applicable, space fill
25B			110-300	191	SPACE FILLER FORMAT: Space Fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**TRANSMISSION TRAILER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER  FORMAT: AAN	<u>REQUIRED</u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION  FORMAT: NNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-300	291	SPACE FILLER  FORMAT: _____  (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**TRANSMISSION HEADER RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Valid Value = 10
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_  (‘_’ indicates 1 space)	<u>REQUIRED</u> Valid Value = D_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<u>REQUIRED</u> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”
9H			38-300	263	SPACE FILLER FORMAT: Space Fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<b>REQUIRED</b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	<b>REQUIRED</b> Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	<b>REQUIRED</b> Valid Value = 10
4A			17-21	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 - 06999
5A			22-30	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
6A			31-39	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (* '_' indicates 1 space)  *Location is the insurer's office responsible for report	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal '0000' Must be a valid 5 or 9 digit Zip Code
7A			40-44	5 Num	SERVICE CO/TPA CODE NUMBER FORMAT: NNNNN	<b>SITUATIONAL</b> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
8A			45-53	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present.)
9A			54-62	9 Num	SERVICE CO/TPA LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘ _ ’ indicates 1 space)  *Location is the Service Co/TPA ’s office responsible for report	<u>SITUATIONAL</u> Must be numeric Left justify and space fill to complete the field 1 <sup>st</sup> four digits must be greater than zero If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present)
10A	2	EMPLOYEE’S SS # OR DIVISION ASSIGNED #	63-71	9 Num	EMPLOYEE IDENTIFICATION NUMBER  (For a division-assigned number go to the division’s web site at <a href="http://www.fldfs.com/wc/organization/odqc.html">http://www.fldfs.com/wc/organization/odqc.html</a> )  FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’
11A	3	DATE OF ACCIDENT	72-79	8 Date	DATE OF ACCIDENT, INJURY OR ILLNESS  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format
12A	1	EMPLOYEE’S NAME	80-109	30 A/N	INJURED EMPLOYEE’S LAST NAME	<u>REQUIRED</u> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
13A	1	EMPLOYEE'S NAME	110-124	15 A/N	INJURED EMPLOYEE'S FIRST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
14A	1	EMPLOYEE'S NAME	125	1 Alpha	INJURED EMPLOYEE'S MIDDLE INITIAL	<b>SITUATIONAL</b> Must be uppercase A-Z If not applicable, space fill
15A	4	EMPLOYEE'S DOB*	126-133	8 Date	INJURED EMPLOYEE'S DATE OF BIRTH FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day  *Or as reported on DFS-F5-DWC-1	<b>REQUIRED</b> Must be valid date in the correct format Must be less than or equal to “Date of Accident”
16A	5	GENDER	134	1 Alpha	INJURED EMPLOYEE'S GENDER  FORMAT: A	<b>REQUIRED</b> F = Female, M = Male, U = Unknown
17A			135-142	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE)  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in correct format Must be greater than or equal to “Date of Accident”
18A			143-150	8 Date	DATE INSURER PAID, ADJUSTED, DISALLOWED OR DENIED BILL  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date Insurer Received Bill From Provider”

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
19A	30	TOTAL REIMB. FROM SECTION 2	151-161	11 Num	TOTAL PHARMACY CHARGES PAID BY INSURER  FORMAT: NNNNNNNNNN	<u>REQUIRED</u> Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field
20A	31	TOTAL REIMB. FROM SECTION 3	162-172	11 Num	TOTAL EQUIPMENT & SUPPLY CHARGES PAID BY INSURER  FORMAT: NNNNNNNNNN	<u>REQUIRED</u> Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field
21A			173-174	2 Num	REPORT REASON CODE  FORMAT: NN  (See Appendix C for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid value
22A	6	CLAIMS HANDLING ENTITY INTERNAL FILE #	175-204	30 A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER  (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field
23A			205-224	20 A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
24A			225-226	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	<u>SITUATIONAL</u> 1 <sup>st</sup> position must be alpha 2 <sup>nd</sup> position must be numeric If field 25A equals “E” then space fill
25A			227	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT/FIRST FILL INDICATOR FORMAT: A OR _  (‘_’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted, Disallowed or Denied Bill” is before the “Date of Service – From” due to an agreement between the provider and the insurer, place a “P” in this field If the Employee has been directly reimbursed by the insurer, place an “E” in this field If First Fill, place a “F” in this field If none of the above are applicable, space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
26A	29	PHARMACIST'S FL DOH LICENSE #	228-240	13 A/N	PHARMACIST'S FL LICENSE NUMBER FORMAT: AANNNNNNNNNNNN (OR) AAANNNNNNNNNNNN (OR) AAAANNNNNNNNNNNN (See Appendix F for valid formats)	<b><u>REQUIRED</u></b> Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
27A			241	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<b><u>SITUATIONAL</u></b> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill
28A			242-300	59	SPACE FILLER FORMAT: Space Fill	<b><u>REQUIRED</u></b> Space fill only

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	<b>REQUIRED</b> Must be numeric NNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	<b>REQUIRED</b> Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	<b>REQUIRED</b> NNN Valid Values = 001-999 Must be numeric Right justify and zero pad on the left to complete field (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B			18	1 Alpha	DRUGS / EQUIPMENT & SUPPLIES RECORD INDICATOR FORMAT: A	<b>REQUIRED</b> Valid Values: D = This is a Drug Detail Record S = This is an Equipment or Supply Detail Record
5B	10 OR 22	QUANTITY	19-23	5 Num	QUANTITY OF MEDICATION (if Drug) OR QUANTITY OF MEDICAL EQUIPMENT OR SUPPLIES (if Equipment or Supplies) FORMAT: NNNNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field
6B	11	DAYS	24-26	3 Num	DAYS SUPPLY OF MEDICATION (if Drug) FORMAT: NNN or Space Fill	<b>SITUATIONAL</b> If 4B = “D” (Drugs): Must be numeric Right justify and zero pad on the left to complete field If 4B = “S” (Equipment or Supplies): Space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7B	9	NDC # (5-4-2 format)	27-39	13 A/N	NATIONAL DRUG CODE NUMBER (if Drug)  FORMAT: NNNNN-NNNN-NN or Space Fill WHERE NNNNN = Manufacturer Code NNNN = Product Code NN = Package Code	<b>REQUIRED</b> If 4B = “D” (Drugs), Must be a valid NDC number All three segments must be numeric Dashes must be in positions 6 and 11, as indicated Right justify and zero pad on the left all segments For compounded drugs, use the following code: 00000-0963-71  <b>SITUATIONAL</b> IF 4B = “S” (Equipment or Supplies), Space fill
8B	14	NEW OR REFILL	40	1 Alpha	PRESCRIPTION – NEW OR REFILL  FORMAT: A	<b>REQUIRED</b> If 4B = “D” (Drugs), N = New, R = Refill  <b>SITUATIONAL</b> IF 4B = “S” (Equipment or Supplies), Space fill
9B			41	1 Alpha	PURCHASE / RENTAL INDICATOR (Equipment and Supplies Only)  FORMAT: A	<b>REQUIRED</b> IF 4B = “S” (Equipment or Supplies) Valid Values: P = Purchased R = Rental  <b>SITUATIONAL</b> If 4B = “D” (Drugs), Space fill
10B	16 OR 19a OR 19b	DATE FILLED OR PURCHASE DATE OR RENTAL DATE	42-49	8 Date	DATE FILLED (if Drug) OR PURCHASE / RENTAL DATE (if Equipment or Supplies)  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date Insurer Received Bill” and “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”, unless Pre-Payment Indicator = P

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
11B	15	DAW CODE	50	1 Num	DISPENSED AS WRITTEN (DAW) CODE (if Drug)  FORMAT: N or Space Fill  (See Appendix K for valid values)	<b><u>REQUIRED</u></b> If 4B = “D” (Drugs)  <b><u>SITUATIONAL</u></b> If 4B = “S” (Equipment or Supplies), Space fill
12B	17b OR 23b	PRESCRIBER’S FL DOH LICENSE #	51-63	13 A/N	PRESCRIBER’S FL LICENSE NUMBER  FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN  (See Appendix F for valid formats)	<b><u>REQUIRED</u></b> Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
13B	13 OR 20	USUAL CHARGE	64-74	11 Num	USUAL CHARGE FOR DRUG, EQUIPMENT OR SUPPLY  FORMAT: NNNNNNNNNNN	<b><u>REQUIRED</u></b> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
14B			75-76	2 Num	EXPLANATION OF BILL REVIEW CODE 1  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>REQUIRED</u></b> Must be valid code
15B			77-78	2 Num	EXPLANATION OF BILL REVIEW CODE 2  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>SITUATIONAL</u></b> Must be valid code If not applicable, space fill
16B			79-80	2 Num	EXPLANATION OF BILL REVIEW CODE 3  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>SITUATIONAL</u></b> Must be valid code If not applicable, space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
17B	21	HCPCS CODE	81-85	5 A/N	HCPCS LEVEL II CODE (if Supply)  FORMAT: NNNNN, OR ANNNN	<b><u>REQUIRED</u></b> IF 4B = “S” (Equipment or Supplies), Must be a valid HCPCS Level II Supply Code  <b><u>SITUATIONAL</u></b> If 4B = “D” (Drugs), Space fill
18B			86-96	11 Num	AMOUNT PAID BY INSURER  FORMAT: NNNNNNNNNN	<b><u>REQUIRED</u></b> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
19B			97-300	204	SPACE FILLER  FORMAT: Space Fill	<b><u>REQUIRED</u></b> Space fill only

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**TRANSMISSION TRAILER RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER  FORMAT: AAN	<b><u>REQUIRED</u></b> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION  FORMAT: NNNNNN	<b><u>REQUIRED</u></b> Must be numeric Right justify and zero pad on the left to complete field
3T			10-300	291	SPACE FILLER  FORMAT: Space Fill	<b><u>REQUIRED</u></b> Space fill only

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**TRANSMISSION HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<b>REQUIRED</b> Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	<b>REQUIRED</b> Valid Value = 11
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ _ (‘_’ indicates 1 space)	<b>REQUIRED</b> Valid Value = D _ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<b>REQUIRED</b> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”
9H			38-300	263	SPACE FILLER FORMAT: Space Fill	<b>REQUIRED</b> Space fill only

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER  FORMAT: SSSYYJJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<b><u>REQUIRED</u></b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG  FORMAT: N	<b><u>REQUIRED</u></b> Valid Value = 1
3A			15-16	2 Num	FORM ID  FORMAT: NN	<b><u>REQUIRED</u></b> Valid Value = 11
4A			17-21	5 Num	INSURER CODE NUMBER  FORMAT: NNNNN	<b><u>REQUIRED</u></b> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 – 06999
5A			22-30	9 Num	INSURER FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<b><u>REQUIRED</u></b> Must be numeric
6A			31-39	9 Num	INSURER LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)  *Location is the insurer’s office responsible for report	<b><u>REQUIRED</u></b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
7A			40-44	5 Num	SERVICE CO/TPA CODE NUMBER  FORMAT: NNNNN	<b><u>SITUATIONAL</u></b> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION N	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
8A			45-53	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present)
9A			54-62	9 Num	SERVICE CO/TPA LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (* _ ' indicates 1 space)  *Location is the Service Co/TPA 's office responsible for report	<u>SITUATIONAL</u> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must be greater than Zero If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present)
10A	8	POLICYHOLDER /SUBSCRIBER IDENTIFIER ID (SSN OR ID#)	63-71	9 Num	EMPLOYEE IDENTIFICATION NUMBER  (For a division-assigned number go to the division's web site at <a href="http://www.fldfs.com/wc/organization/odqc.html">http://www.fldfs.com/wc/organization/odqc.html</a> )  FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be SSN or Division-Assigned Number Division-Assigned Number must begin with '0000'
11A	46	DATE OF ACCIDENT	72-79	8 Date	DATE OF ACCIDENT, INJURY OR ILLNESS  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be less than or equal to "Date of Service"
12A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	80-109	30 A/N	INJURED EMPLOYEE'S LAST NAME	<u>REQUIRED</u> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
13A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	110-124	15 A/N	INJURED EMPLOYEE’S FIRST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
14A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	125	1 Alpha	INJURED EMPLOYEE’S MIDDLE INITIAL	<b>SITUATIONAL</b> If applicable, must be uppercase A-Z If not applicable, leave unused space blank
15A	21	DATE OF BIRTH*	126-133	8 Date	INJURED EMPLOYEE’S DATE OF BIRTH FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day  *Or as reported on DFS-F5-DWC-1	<b>REQUIRED</b> Must be valid date in the correct format Must be less than or equal to “Date of Accident”
16A	22	GENDER	134	1 Alpha	INJURED EMPLOYEE’S GENDER  FORMAT: A	<b>REQUIRED</b> F = Female, M = Male, U = Unknown
17A	55	LICENSE NUMBER	135-147	13 A/N	PROVIDER’S FLORIDA LICENSE NUMBER  FORMAT: AANNNNNNNNNN (See Appendix F for valid formats)	<b>REQUIRED</b> Key alpha prefix and numeric digits of license number Left justify and space fill to end of field Must be valid value DO NOT zero pad numeric portion
18A	51	SSN or TIN	148-156	9 Num	PROVIDER FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
19A	56	ADDRESS, CITY, STATE, ZIP CODE	157-165	9 Num	PROVIDER LOCATION ZIP CODE  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)	<b>REQUIRED</b> Must be numeric Left justify and leave unused spaces blank 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
20A	38	PLACE OF TREATMENT	166-167	2 Num	PLACE OF TREATMENT  FORMAT: NN  (See Appendix B For Valid Codes)	<b>REQUIRED</b> Must be numeric Must be valid code

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
21A			168-175	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service”
22A			176-183	8 Date	DATE INSURER PAID, ADJUSTED, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider”
23A			184-194	11 Num	TOTAL PAID BY INSURER FORMAT: NNNNNNNNNNN	<b>REQUIRED</b> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
24A			195-196	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	<b>REQUIRED</b> Must be numeric Must be a valid value
25A			197-198	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	<b>SITUATIONAL</b> 1 <sup>st</sup> position must be alpha 2 <sup>nd</sup> position must be numeric If field 28A equals “E”, space fill
26A			199-228	30 A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER (From the Insurer/TPA’s office file)	<b>REQUIRED</b> Left justify and space fill to end of field
27A			229-248	20 A/N	SUBMITTER LOCATION	<b>SITUATIONAL</b> Left justify and space fill to end of field If not applicable, space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM HEADER RECORD LAYOUT– REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
28A			249	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted, Disallowed or Denied Bill” is before the “Date of Service – From” due to an agreement between the provider and the insurer, place a "P" in this field If the Employee has been directly reimbursed by the insurer, place an “E” in this field If none of the above are applicable, space fill
29A			250	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill
30A			251-300	50	SPACE FILLER FORMAT: Space Fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT- REVISION "D"**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<b>REQUIRED</b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	<b>REQUIRED</b> Must be numeric Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	<b>REQUIRED</b> Must be numeric NNN Valid Values = 001-999 Left pad with zeros to fill all 3 digits (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	24	PROCEDURE DATE	18-25	8 Date	DATE OF SERVICE/TREATMENT FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be a valid date in the correct format Must be greater than or equal to "Date of Accident" Must be less than or equal to "Date Insurer Received Bill from Provider" and "Date Insurer Paid, Adjusted, Disallowed or Denied Bill", unless Pre-Pay Indicator = P
5B	29	PROCEDURE CODE	26-30	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY PROVIDER)  FORMAT: NNNNN, OR ANNNN	<b>REQUIRED</b> Must be a valid CPT, CDT, HCPCS 'D' or Unique Florida WC code
6B			31-35	5 A/N	PAID CPT, CDT OR HCPCS CODE  FORMAT: NNNNN, OR ANNNN	<b>REQUIRED</b> Must be a valid CPT, CDT, HCPCS 'D' or Unique Florida WC code

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7B	31	FEE	36-46	11 Num	PROVIDER CHARGE PER LINE  FORMAT: NNNNNNNNNNN	<b><u>REQUIRED</u></b> Must be numeric Decimal point is implied at 2 places Right justify and zero pad on the left to complete field
8B			47-57	11 Num	INSURER PAYMENT PER LINE*  FORMAT: NNNNNNNNNNN  *After all adjustments have been applied.	<b><u>REQUIRED</u></b> Must be numeric Decimal point is implied at 2 places Right justify and zero pad on the left to complete field
9B			58-59	2 Num	EXPLANATION OF BILL REVIEW CODE 1  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>REQUIRED</u></b> Must be valid code
10B			60-61	2 Num	EXPLANATION OF BILL REVIEW CODE 2  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>SITUATIONAL</u></b> Must be valid code If not applicable, space fill
11B			62-63	2 Num	EXPLANATION OF BILL REVIEW CODE 3  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b><u>SITUATIONAL</u></b> Must be valid code If not applicable, space fill
12B			64-300	237	SPACE FILLER  FORMAT: Space Fill	<b><u>REQUIRED</u></b> Space fill only

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 300**

**TRANSMISSION TRAILER RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER  FORMAT: AAN	<u><b>REQUIRED</b></u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION.  FORMAT: NNNNNN	<u><b>REQUIRED</b></u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-300	291	SPACE FILLER  FORMAT: Space Fill	<u><b>REQUIRED</b></u> Space fill only

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 450**

**TRANSMISSION HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<b>REQUIRED</b> Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ ___ OR NNNNNNNNN  (‘_’ indicates 1 space)	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	<b>REQUIRED</b> Valid Value = 90
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_  (‘_’ indicates 1 space)	<b>REQUIRED</b> Valid Value = D_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<b>REQUIRED</b> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”
9H			38-450	413	SPACE FILLER FORMAT: Space Fill	<b>REQUIRED</b> Space fill only

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<b>REQUIRED</b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	<b>REQUIRED</b> Valid Value = 1
3A			15-16	2 Num	FORM IDENTIFIER FORMAT: NN	<b>REQUIRED</b> Valid Value = 90
4A			17-21	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 - 06999
5A			22-30	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
6A	50	PAYER NAME	31-39	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ OR NNNNNNNNN  (‘_’ indicates 1 space)  *Location is the insurer’s office responsible for report	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not = ‘0000’ Must be a valid 5 or 9 digit Zip Code

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7A			40-44	5 Num	SERVICE CO/TPA CODE NUMBER  FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill
8A			45-53	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER  FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present)
9A			54-62	9 Num	SERVICE CO/TPA LOCATION ZIP CODE*  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (‘_’ indicates 1 space)  *Location is the Service Co/TPA’s office responsible for report	<u>SITUATIONAL</u> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present)
10A	4	TYPE OF BILL	63-65	3 A/N	TYPE OF REPORT  FORMAT: NNN, OR NNA  (See UB-04 Manual for valid codes for form locator 4)	<u>REQUIRED</u> Must be valid code
11A	8a	PATIENT’S NAME	66-74	9 Num	EMPLOYEE IDENTIFICATION NUMBER  (For a division-assigned number go to the division’s web site at <a href="http://www.fldfs.com/wc/organization/odqc.html">http://www.fldfs.com/wc/organization/odqc.html</a> )  FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
12A	31	OCCURRENCE DATE	75-82	8 Date	DATE OF ACCIDENT, ILLNESS OR INJURY  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be less than or equal to date of “Statement Covers Period From and Through” Must be less than or equal to “Admission Date”
13A	8b	PATIENT NAME	83-112	30 A/N	INJURED EMPLOYEE’S LAST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
14A	8b	PATIENT NAME	113-127	15 A/N	INJURED EMPLOYEE’S FIRST NAME	<b>REQUIRED</b> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
15A	8b	PATIENT NAME	128	1 Alpha	INJURED EMPLOYEE’S MIDDLE INITIAL	<b>SITUATIONAL</b> If applicable, must be uppercase A-Z If not applicable, space fill
16A	10	BIRTHDATE*	129-136	8 Date	INJURED EMPLOYEE’S DATE OF BIRTH  FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day  *Or as reported on DFS-F5-DWC-1	<b>REQUIRED</b> Must be a valid date in the correct format Must be less than or equal to “Date of Accident”
17A	11	SEX	137	1 Alpha	INJURED EMPLOYEE’S GENDER  FORMAT: A	<b>REQUIRED</b> F = Female, M = Male, U = Unknown

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
18A	76	ATTENDING QUAL	138-150	13 A/N	ATTENDING PHYSICIAN'S FLORIDA PROVIDER LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN (See Appendix F for valid formats)	<b>REQUIRED</b> Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
19A	77	OPERATING QUAL	151-163	13 A/N	OPERATING PHYSICIAN'S FLORIDA PROVIDER LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN (See Appendix F for valid formats)	<b>SITUATIONAL</b> Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
20A	12	ADMISSION DATE	164-171	8 Date	ADMISSION DATE FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to the “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”
21A	13	ADMISSION HR	172-173	2 Num	ADMISSION HOUR FORMAT: NN (See UB-04 manual for valid codes)	<b>SITUATIONAL</b> Must be numeric Must be valid code If first digit in form locator 4 (field 10A) equals 1 and second digit equals 1, 2, or 8, then field must be filled

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH / TYPE	DESCRIPTION	REQUIREMENTS
22A	6	STATEMENT COVERS PERIOD: FROM	174-181	8 Date	DATE STATEMENT COVERS FROM FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date Statement Covers Through” date Must be less than or equal to the “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted, Disallowed or Denied Bill”, unless Pre-Pay Indicator = P
23A	6	STATEMENT COVERS PERIOD: THROUGH	182-189	8 Date	DATE STATEMENT COVERS THROUGH FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date Statement Covers From”
24A	16	DHR	190-191	2 Num	DISCHARGE HOUR FORMAT: NN  (See UB-04 manual for valid codes)	<b>SITUATIONAL</b> Must be numeric Must be valid code If first digit in form locator 4 (field 10A) equals 1 and second digit equals 1, 2, or 8, then field must be filled All other situations, space fill
25A	5	FED. TAX NO.	192-200	9 Num	FACILITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<b>REQUIRED</b> Must be numeric
26A	1	BLANK	201-209	9 Num	FACILITY LOCATION ZIP CODE FORMAT: NNNNN_ OR NNNNNNNNN  (‘_’ indicates 1 space)	<b>REQUIRED</b> Must be numeric Left justify and space fill to end of field 1 <sup>st</sup> four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
27A			210-217	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Admission Date” Must be greater than or equal to “Date Statement Covers From and Through”

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
28A			218-225	8 Date	DATE INSURER PAID, ADJUSTED, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<b>REQUIRED</b> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider” Must be greater than or equal to “Admission Date” Must be greater than or equal to “Date Statement Covers From and Through”
29A			226-236	11 Num	TOTAL PAID BY INSURER FORMAT: NNNNNNNNNN	<b>REQUIRED</b> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
30A	67	DX	237-244	8 A/N	PRIMARY ICD-9 DIAGNOSTIC CODE FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>REQUIRED</b> Must be a valid ICD-9 code Left justify and space fill to end of field
31A	67A	DX	245-252	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 1 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>SITUATIONAL</b> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
32A	67B	DX	253-260	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 2 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>SITUATIONAL</b> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
33A	67C	DX	261-268	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 3 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>SITUATIONAL</b> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
34A	67D	DX	269-276	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 4 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>SITUATIONAL</b> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
35A	67E	DX	277-284	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 5 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<b>SITUATIONAL</b> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
36A	67F	DX	285-292	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 6 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
37A	67G	DX	293-300	8 A/N	OTHER ICD-9 DIAGNOSTIC CODE 7 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
38A	72A	ECI	301-308	8 A/N	EXTERNAL CAUSE OF INJURY CODE 1 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Required if the bill is related to an injury Must be a valid ICD-9 injury code. If bill is not related to an injury, space fill
39A	72B	ECI	309-316	8 A/N	EXTERNAL CAUSE OF INJURY CODE 2 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Required if the bill is related to an injury and at least two external cause of injury codes are reported Must be a valid ICD-9 injury code If not applicable, space fill
40A	72C	ECI	317-324	8 A/N	EXTERNAL CAUSE OF INJURY CODE 3 FORMAT: See Appendix A for Valid Diagnosis Code Formats	<u>SITUATIONAL</u> Required if the bill is related to an injury and at least two external cause of injury codes are reported Must be a valid ICD-9 injury code If not applicable, space fill
41A	74	PRINCIPAL PROCEDURE	325-329	5 A/N	PRINCIPAL PROCEDURE CODE FORMAT: NNNNN, ANNNN OR NN.NN (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> Must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
42A	74a	a. OTHER PROCEDURE CODE	330-334	5 A/N	OTHER PROCEDURE CODE A FORMAT: NNNNN, ANNNN OR NN.NN (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
43A	74b	b. OTHER PROCEDURE CODE	335-339	5 A/N	OTHER PROCEDURE CODE B FORMAT: NNNNN, ANNNN OR NN.NN  (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
44A	74c	c. OTHER PROCEDURE CODE	340-344	5 A/N	OTHER PROCEDURE CODE C FORMAT: NNNNN, ANNNN OR NN.NN  (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
45A	74d	d. OTHER PROCEDURE CODE	345-349	5 A/N	OTHER PROCEDURE CODE D FORMAT: NNNNN, ANNNN OR NN.NN  (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
46A	74e	e. OTHER PROCEDURE CODE	350-354	5 A/N	OTHER PROCEDURE CODE E FORMAT: NNNNN, ANNNN OR NN.NN  (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
47A			355-356	2 Num	REPORT REASON CODE FORMAT: NN  (See Appendix C for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid value
48A			357-358	2 A/N	PAYMENT CODE FORMAT: AN  (See Appendix D for Valid Codes)	<u>SITUATIONAL</u> 1 <sup>st</sup> position must be alpha 2 <sup>nd</sup> position must be numeric If field 52A equals “E”, space fill
49A	14	ADMISSION TYPE	359	1 Num	TYPE OF ADMISSION/VISIT FORMAT: N  (See UB-04 Manual for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid code
50A			360-389	30 A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER  (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
51A			390-409	20 A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
52A			410	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted, Disallowed or Denied Bill” is before the “Date of Service – From” due to an agreement between the provider and the insurer, place a "P" in this field If the Employee has been directly reimbursed by the insurer, place an “E” in this field If none of the above are applicable, space fill
53A			411	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _  (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill
54A	80	REMARKS	412	1 Alpha	SCHEDULED/UNSCHEDULED INDICATOR  FORMAT: A	<u>SITUATIONAL</u> If applicable, insert code value as follows: S = The bill is related to a scheduled outpatient surgical procedure U = The bill is related to a non-scheduled outpatient surgical procedure Space fill, if bill is not related to an outpatient surgical procedure
55A	80	REMARKS	413-423	11 Num	IMPLANT TOTAL PAID FORMAT: NNNNNNNNNN	<u>SITUATIONAL</u> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete If not applicable, space fill
56A			424-450	27	SPACE FILLER FORMAT: Space Fill	<u>REQUIRED</u> Space fill only

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION  
RECORD LENGTH: 450  
CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER  FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<b><u>REQUIRED</u></b> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG  FORMAT: N	<b><u>REQUIRED</u></b> Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER  FORMAT: NNN	<b><u>REQUIRED</u></b> NNN Valid Values = 001-999 Must be numeric Right justify and zero pad on the left to complete field Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	42	REVENUE CODE	18-21	4 Num	REVENUE CODE  FORMAT: NNNN  (See UB-04 Manual for Valid Codes)	<b><u>REQUIRED</u></b> Must be numeric Must be a valid code Right justify and zero pad on the left to complete field
5B	44	HCPCS/RATES	22-26	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY THE PROVIDER)  FORMAT: NNNNN or ANNNN	<b><u>SITUATIONAL</u></b> Must be valid CPT, HCPCS or Unique WC code Left justify and space fill to end of field If not applicable, space fill
6B	44	HCPCS/RATES	27-28	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS BILLED BY THE PROVIDER)  FORMAT: NN OR, AN OR, AA	<b><u>SITUATIONAL</u></b> Must be valid CPT or HCPCS modifier code If not applicable, space fill

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 450**

**CLAIM DETAIL RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7B	46	SERVICE UNITS	29-35	7 Num	UNITS OF SERVICE FORMAT: NNNNNNN	<b>REQUIRED</b> Must be numeric Right justify and zero pad on the left to complete field
8B	47	TOTAL CHARGES	36-46	11 Num	CHARGE PER REVENUE CODE FORMAT: NNNNNNNNNNN  (Do not enter credits in this field)	<b>REQUIRED</b> Must be numeric Decimal point implied at 2 places Right justify and zero pad on the left to complete field
9B			47-48	2 Num	EXPLANATION OF BILL REVIEW CODE 1  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b>REQUIRED</b> Must be valid code
10B			49-50	2 Num	EXPLANATION OF BILL REVIEW CODE 2  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b>SITUATIONAL</b> Must be valid code If not applicable, space fill
11B			51-52	2 Num	EXPLANATION OF BILL REVIEW CODE 3  FORMAT: NN  (See Appendix E for valid EOBR Codes)	<b>SITUATIONAL</b> Must be valid code If not applicable, space fill
12B	45	SERVICE DATE	53-60	8 Date	DATE OF OUTPATIENT SERVICE	<b>SITUATIONAL</b> Must be valid date in the correct format Must be present if first digit in field 10A = ‘1’ AND the second digit = ‘3’ If not applicable, space fill
13B			61-450	390	SPACE FILLER FORMAT: Space Fill	<b>REQUIRED</b> Space fill only

**FORM DFS-F5-DWC-90 (UB-04 CMS -1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)  
 FILE LAYOUT FOR ELECTRONIC SUBMISSION  
 RECORD LENGTH: 450**

**TRANSMISSION TRAILER LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER  FORMAT: AAN	<b><u>REQUIRED</u></b> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF REPORTS IN TRANSMISSION  FORMAT: NNNNNN	<b><u>REQUIRED</u></b> Must be numeric Right justify and zero pad on the left to complete field
3T			10-450	441	SPACE FILLER  FORMAT: Space Fill	<b><u>REQUIRED</u></b> Space fill only

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION  
FILE LAYOUT  
RECORD LENGTH: 300**

**TRANSMISSION HEADER RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	NOTES
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER  FORMAT: AAN	Hard coded as HD1
2H			4-6	3 Num	SUBMITTER ID  FORMAT: NNN	Will be numeric and right justified with zero padding on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE  FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN  (* _ ' indicates 1 space)	Will be numeric Will be left justified and space filled to end of field
4H			16-23	8 Num	TRANSMISSION ID NUMBER ASSIGNED  FORMAT: NNNNNNNN	Will contain division assigned Transmission ID Will be numeric and left justified (Current Transmission ID numbers are only 7 digits long, but we are reserving 8 digits for future expansion.)
5H			24-25	2 Num	FORM ID  FORMAT: NN	Will be numeric Values = 09, 10, 11, or 90
6H			26	1 Alpha	TEST / PRODUCTION INDICATOR  FORMAT: A	Values : T = Test Transmission P = Production Transmission
7H			27 - 29	3 Alpha	FILE LAYOUT REVISION	Hard coded as “D” for this release of the Medical Claim Processing Report file
8H			30-300	271	SPACE FILLER  FORMAT: Space Fill	Space fill only

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION  
FILE LAYOUT  
RECORD LENGTH: 300**

**CLAIM PROCESSING RESPONSE RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
1K			1-3	3 A/N	RECORD TYPE INDICATOR	Hard coded as CP1
2K			4-16	13 Num	CLAIM CONTROL NUMBER  FORMAT: SSSYYJJNNNNN SSS= SUBMITTER ID YY= Year submitted JJJ= Julian date of day submitted NNNNN = Sequence number	Will be numeric, matching control number submitted
3K			17-18	2 Num	FORM ID  FORMAT: NN	Values = 09, 10, 11, or 90
4K			19-20	2 Alpha	SUBMISSION REASON CODE	Will repeat the submission reason code submitted in the data file
5K			21-30	10 Alpha	PROCESSING RESULT CODE  See Appendix G for Values.	Code will indicate the result of processing of the claim
6K			31-40	10 Alpha	BYPASS REASON CODE  See Appendix H for Values.	If the Processing Result Code = BYPASSED, this will contain a reason code why it could not be processed
7K			41-70	30 A/N	INSURER/SERVICE CO/TPA FILE NUMBER	Will contain the file number submitted in the data file
8K			71-90	20 A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Will contain the SUBMITTER LOCATION submitted in the data file
9K			91-98	8 Date	DATE DIVISION ACCEPTED, REJECTED, WITHDREW OR BYPASSED.	FORMAT: YYYYMMDD
10K			99-248	150 A/N	NARRATIVE TEXT	Will contain an explanation of why the claim could not be processed (if it was bypassed)
11K			249-300	52	SPACE FILLER FORMAT: Space Fill	Space fill only

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION  
FILE LAYOUT  
RECORD LENGTH: 300**

**CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “D”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
1E			1-3	3 A/N	RECORD TYPE INDICATOR	Hard coded as ER1
2E			4-16	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS= SUBMITTER ID YY= Year submitted JJJ= Julian date of day submitted NNNN = Sequence number	Will be numeric, matching control number submitted
3E			17-19	3 Num	ERROR SEQUENCE NUMBER FORMAT: NNN Examples: 001, 002, 003...	Uniquely identifies each error associated with a claim Will be right justified and zero padded to complete field
4E			20-22	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN Examples: 000, 001, 002...	Will contain the Detail Sequence Number that this error corresponds to. It will contain 000 if the error is associated with the claim's header record
5E			23-25	3 Num	ERROR CODE FORMAT: NNN Examples: 058, 028  See Appendix I for Values.	Code will indicate the type of error encountered
6E			26-29	4 A/N	MEIG FIELD ID NUMBER Examples: 4A, 12B	Contains the MEIG field number that is being rejected
7E			30-33	4 A/N	PAPER FORM FIELD NUMBER Examples: 1, 6D, 24F	Contains the corresponding paper form field number
8E			34-37	4 A/N	COMPARISON MEIG FIELD ID NUMBER Examples: 4A, 12B	When the validation rule is comparing to values in the supplied claim, this will contain the 2 <sup>nd</sup> MEIG field number being compared

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION  
FILE LAYOUT  
RECORD LENGTH: 300**

**CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “D”**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>NOTES</b>
9E			38–41	4 A/N	COMPARISON PAPER FORM FIELD NUMBER  Examples: 1, 6D, 24F	When the validation rule is comparing to values in the supplied claim, this will contain the 2 <sup>nd</sup> paper form field number being compared
10E			42–66	25 A/N	RAW REJECTED VALUE	Contains the actual rejected value supplied The value will be truncated to 25 characters for rejected fields longer than 25 characters
11E			67–91	25 A/N	COMPARISON RAW VALUE	When the validation rule is comparing two values in the supplied claim, this will contain the 2 <sup>nd</sup> raw value that was compared
12E			92–241	150 A/N	NARRATIVE ERROR MESSAGE	Error message corresponding to the Error Code given in field 5E
13E			242–300	59	SPACE FILLER  FORMAT: Space Fill	Space fill only

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION  
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

**RECORD LENGTH: 300**

**TRANSMISSION TRAILER RECORD LAYOUT- REVISION "D"**

<b>FIELD NO.</b>	<b>FORM FIELD ID</b>	<b>FORM FIELD NAME</b>	<b>LOCATION</b>	<b>LENGTH/ TYPE</b>	<b>DESCRIPTION</b>	<b>REQUIREMENTS</b>
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER  FORMAT: AAN	Will be hard coded as TR1
2T			4-9	6 Num	NUMBER OF CLAIM PROCESSING RESULTS IN TRANSMISSION  FORMAT: NNNNNN	Will be numeric and right justified and space filled to complete field
3T			10-300	291	SPACE FILLER  FORMAT: Space Fill	Space fill only

# **APPENDICES**

# APPENDIX A

## ICD-9 Diagnosis Code and ICD-9 Procedure Code Formats

(Forms DFS-F5-DWC-9 and DFS-F5-DWC-90)

### If ICD-9 Diagnosis Code Is:

### Valid Format Is:

942	942
942.	942
942.0	942.0
372.61	372.61
043.9	043.9
005.9	005.9
V03	V03
V03.	V03
V03.0	V03.0
V03.7	V03.7
E111	E111
E111.	E111
E111.0	E111.0
E111.9	E111.9

(Form DFS-F5-DWC-90)

### If ICD-9 Procedure Code Is:

### Valid Format Is:

01.0	01.0
01.01	01.01

**NOTE:** Be sure to key in the decimal point. If a letter is used, make sure it is capitalized. Left justify.

**EXCEPTIONS:** Do NOT key the decimal for diagnosis codes containing no digits to the right of the decimal; instead, left justify and space fill to the end of the field. For HOSPITAL BILLING, key diagnosis according to the UB-04 Manual.

# APPENDIX B

## Place of Treatment Codes

(Form DFS-F5-DWC-11)

<u>Place of Treatment (Location)</u>	<u>Valid Codes</u>
Provider's Office	11
Hospital	23
Extended Care Facility (ECF)	31
Other Unlisted	99

# APPENDIX C

## Report Reason Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10,  
DFS-F5-DWC-11 and DFS-F5-DWC-90)

<u>Reason Description</u>	<u>Valid Codes</u>
Original Submission to the division	00
Cancel/ Withdraw – report sent to the division in error ( <b>Claim must be submitted with original control number</b> )	01
Correction of report previously rejected by the division ( <b>Claim must be submitted with original control number</b> )	02
Replacement report for claims previously accepted by the division ( <b>Claim must be submitted with original control number</b> )	03
Automatically Select Report Reason Code 00 or 02*	99

\*System will automatically select Report Reason Code 00 or 02, according to the following rules:

If the claim control number is not currently in our database, it will automatically select Report Reason Code 00.

If the claim is in our database and is currently **Rejected**, it will automatically select Report Reason Code 02.

If the claim is in our database and is currently **Accepted** or **Withdrawn**, it will automatically select Report Reason Code 00 and bypass the processing.

Using Report Reason Code 99 allows for the entire original transmission file to be re-submitted using the same control numbers as many times as necessary until all of the claims have been corrected and accepted. The claims that have already been accepted will be bypassed and not processed by our system.

# APPENDIX D

## Payment Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90)

Payment Code is a two-position field. Each of the two positions has a distinct meaning.

The left position designates the payment plan, as described below:

<u>Payment Plan</u>	<u>Valid Codes</u>
<b>Reimbursement Manual</b> (Services are reimbursed according to the appropriate reimbursement manual)	<b>R</b>
<b>Managed Care</b> (Services are reimbursed according to the language of the WC Managed Care Arrangement contract)	<b>M</b>
<b>Contracted Amount</b> (Services are reimbursed according to a contract not associated with a WC Managed Care Arrangement)	<b>C</b>

The right position indicates the insurer’s documented business arrangement that identifies the “date insurer received” and “date insurer paid” as they relate to medical bill processing.

The medical bill claims-handling arrangements and corresponding values for the right position are described below:

<u>Receipt and Payment Arrangement</u>	<u>Valid Codes</u>
“Date insurer received” and “date insurer paid, adjusted, disallowed or denied” are based on payment and receipt by the insurer.	<b>1</b>
“Date insurer received” and “date insurer paid, adjusted, disallowed, or denied” are based on payment and receipt by the entity.	<b>2</b>
“Date insurer received” is based on the date received by the insurer and “date insurer paid, adjusted, disallowed or denied” is based on payment by the entity.	<b>3</b>
“Date insurer received” is based on the date received by the entity and “date insurer paid, adjusted, disallowed or denied” is based on insurer payment.	<b>4</b>

# APPENDIX E

## Explanation of Bill Review (EOBR) Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90)

<b><u>EOBR Description</u></b>	<b><u>Valid Codes</u></b>
Payment denied: compensability: injury or illness for which service was rendered is not compensable.	10
Payment disallowed: medical necessity: medical records reflect no physician's order was given for service rendered or supply provided.	21
Payment disallowed: medical necessity: medical records reflect no physician's prescription was given for service rendered or supply provided.	22
Payment disallowed: medical necessity: diagnosis does not support the service rendered.	23
Payment disallowed: medical necessity: service rendered was not therapeutically appropriate.	24
Payment disallowed: medical necessity: service rendered was experimental, investigative or research in nature.	25
Payment disallowed: service rendered by health care practitioner outside scope of practitioner's licensure.	26
Payment disallowed: lack of authorization: no authorization given for service rendered.	30
Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered.	40
Payment disallowed: insufficient documentation: level of evaluation and management service not supported by documentation.	41
Payment disallowed: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.	42
Payment disallowed: insufficient documentation: frequency of service not supported by documentation.	43
Payment disallowed: insufficient documentation: duration of service not supported by documentation.	44
Payment disallowed: insufficient documentation: fraud statement not provided pursuant to s.440.105(7), F.S.	45

## **Explanation of Bill Review (EOBR) Codes (Continued)**

<b><u>EOBR Description</u></b>	<b><u>Valid Codes</u></b>
Payment disallowed: insufficient documentation: required itemized statement not submitted with the medical bill.	46
Payment disallowed: insufficient documentation: invoice not submitted for implant.	47
Payment disallowed: insufficient documentation: invoice not submitted for supplies.	48
Payment disallowed: insufficient documentation: invoice not submitted for medication.	49
Payment disallowed: insufficient documentation: requested documentation not submitted with the medical bill.	50
Payment disallowed: insufficient documentation: required DFS-F5-DWC-25 not submitted.	51
Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure.	52
Payment disallowed: insufficient documentation: required operative report not submitted with the medical bill.	53
Payment disallowed: insufficient documentation: required narrative report not submitted with the medical bill.	54
Payment disallowed: billing error: service previously billed and processed on prior medical bill.	60
Payment disallowed: billing error: same service billed multiple times on same date of service.	61
Payment disallowed: billing error: incorrect procedure, modifier or supply code.	62
Payment disallowed: billing error: service billed is integral component of another procedure code.	63
Payment disallowed: billing error: service “not covered” under applicable workers’ compensation reimbursement manual.	64
Payment disallowed: billing error: multiple providers billed on the same form.	65
Payment adjusted: insufficient documentation: level of evaluation and management service not supported by documentation.	71

## **Explanation of Bill Review (EOBR) Codes (Continued)**

<b><u>EOBR Description</u></b>	<b><u>Valid Codes</u></b>
Payment adjusted: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.	72
Payment adjusted: insufficient documentation: frequency of service not supported by documentation.	73
Payment adjusted: insufficient documentation: duration of service not supported by documentation.	74
Payment adjusted: insufficient documentation: requested documentation not submitted with the medical bill.	75
Payment adjusted: billing error: correction of procedure, modifier or supply code.	80
Payment adjusted: billing error: payment modified pursuant to a charge audit.	81
Payment adjusted: payment modified pursuant to carrier charge analysis.	82
Payment adjusted: medical benefits paid apportioning out the percentage of the need for such care attributable to preexisting condition (s.440.15(5)(b), F.S.).	83
Payment adjusted: co-payment applied pursuant to s.440.13(14)(c), F.S.	84
Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Health Care Provider Reimbursement Manual.	90
Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.	91
Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Hospitals.	92
Paid: no modification to the information provided on the medical bill: payment made pursuant to contractual arrangement.	93
Paid: Out-of-State Provider: payment made pursuant to the Out-of-State Provider Section of the applicable Florida reimbursement manual.	94
Paid: Reimbursement Dispute Resolution: payment made pursuant to receipt of a Determination or Final Order on a Petition for Resolution of Reimbursement Dispute, pursuant to s.440.13(7), F.S.	95

*(Contact the Office of Medical Services at 850-413-1613 for direction on the proper usage of EOBR codes.)*

# APPENDIX F

## Proper Provider License Number Formats

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90)

**Advanced Registered Nurse Practitioners:** Enter “ARNP” followed by their Florida medical license number (ARNP#####).

**Ambulatory Surgical Centers:** Enter “ASC” followed by the Agency for Health Care Administration assigned license number (ASC#####).

**Independent Laboratories:** Enter “IL”, for required alpha characters, followed by the Agency for Health Care Administration assigned license number (IL8#####).

**Individual Health Care Providers, Physicians, and Therapists:** Enter the Florida health care provider’s or rehabilitation facility’s prefix and license number assigned by the professional regulatory board, licensing authority, or state regulatory agency.

**Out-of-state Providers:** Code “ZZ9999999999” for the provider license number.

**Radiology or Other Facilities (providing ONLY the technical component):** Code “XX9999999999” for the license number.

**Work Hardening/Pain Programs:** Enter the Division of Vocational Rehabilitation assigned facility number.  
WC1##### = Individual Qualified Rehabilitation Provider  
WC2##### = Rehabilitation Facility  
WC3##### = Rehabilitation Company (Individual QRPs sometimes are employed by and bill through these Rehabilitation Companies.)

# APPENDIX G

## Claim Processing Result Codes

The following is a list of claim processing result codes from the division's Medical Data Management System:

<u>CODE</u>	<u>MEANING</u>
ACCEPTED	The claim was accepted into the division's database.
REJECTED	The claim was processed but failed one or more of the validation tests. This claim must be corrected and resubmitted to the division.
WITHDRAWN	The Cancel/Withdraw claim (01) was successfully withdrawn from the division's database.
REPLACED	The Replacement claim (03) was accepted as a replacement in the division's database.
BYPASSED	The claim could not be processed. Refer to the Bypass Reason Codes on page 72.

# APPENDIX H

## Bypass Reason Codes

The following is a list of bypass reason codes that are possible when a submitted claim could not be processed by the division's Medical Data Management System:

<b><u>CODE</u></b>	<b><u>MEANING</u></b>
ALRDYACCP	The claim is being submitted as a Correction claim (02) or Automatic Reason (99), but the claim was found to be currently accepted in the division's database.
NOTFOUND	The claim is being submitted as a Correction (02), Replacement (03), or Cancel/Withdraw (01), but the claim could not be located in the database.
NOTORIG	The claim is being submitted as an Original submission (00), but the claim is already present in our database.
ALRDYWITH	The claim is being submitted as a Cancel/Withdraw (01), but the claim is already coded as Cancelled/Withdrawn in the division's database.
NOTREJCTD	The claim is being submitted as a Correction claim (02), but the claim is not currently rejected in the division's database.
INSIDDIF	The INSURER ID NUMBER on the submitted claim is different from ID number on the current copy of this claim in our database.
NOREPWITH	No Replacement (03) submissions allowed against a withdrawn claim.
NOREPREJ	No Replacement (03) submissions allowed against a rejected claim (use Correction (02) submission instead).
TRYTOMRW	Cancel/Withdrawal Claim xyz is an old claim that has been archived and will be restored tonight. Resubmit this claim tomorrow (processing bypassed).

# APPENDIX I

## Validation Error Codes

The following is a list of Validation Error Codes reported by the division's Medical Data Management System:

<b><u>CODE</u></b>	<b><u>MEANING</u></b>
028	Must be numeric
029	Must be a valid date (CCYYMMDD)
034	Must be greater than or equal to the date of accident
039	No matching code value found in database
041	Cannot be a future date
057	Comparison of key fields indicates duplicate claim
058	Invalid code, ID, or value specified
060	Date comparison validation failure
062	Claim detail record(s) missing
066	Insurer/TPA not authorized for submitter
069	Total paid in header does not equal sum of detail paid amounts
070	Blank or zero value not allowed
071	FEIN does not match division records
072	License number not found in our database
073	Diagnosis reference number given does not have a corresponding header diagnosis
074	EOBR code present indicates non-payment, but item was paid
075	CPT code paid different than billed, but appropriate EOBR code not reported
076	Modifier code paid different than billed, but appropriate EOBR code not reported
077	Amount paid different than billed, but appropriate EOBR code not reported
078	Amount paid is zero, but appropriate EOBR code not reported
079	Service Co./TPA FEIN or zip supplied, but ID number not supplied
080	Date of accident is after insurer cancellation date
081	NDC number supplied, but procedure code paid not equal to 96370

## Validation Error Codes (continued)

<u>CODE</u>	<u>MEANING</u>
083	The EOBR code reported requires the line item payment amount to be equal to zero
085	The EOBR code reported requires the line item payment amount to be greater than zero
086	The EOBR code reported is for hospital (DWC-90) use only
088	For EOBR code reported, line item payment must equal line item billed amount
091	Procedure code paid 99070 reported, but NDC number not space filled
092	Procedure code paid 96370 reported, but NDC number space filled
094	Place of service code must equal 24 if ASC license number is reported
095	Duplicate override indicator privileges have been suspended for this submitter
096	Adjustment EOBR code reported, but line item payment amount equals billed amount
097	Inappropriate EOBR code reported for hospital emergency room services
098	EOBR code reported not allowed in conjunction with payment code of "R"

# APPENDIX J

## Electronic File Naming Conventions

Please use the following file naming convention for files uploaded to the division:

**STTTTTDWCXX\_YYYYMMDD\_HHMMSSZ.TXT**

Example: **SMTP123DWC09\_20020929\_090500T.TXT**

### Where

“**S**” is hard coded. (All files submitted must start with the letter “S”.)

“**TTTTTT**” is your 6 digit Submitter ID (i.e. – MTP123)

“**DWC**” is hard coded and must always be present in the file name.

“**XX**” is the Form Type. Current valid Form Type values are as follows:

“**09**” = DWC-9 Medical Claim Form

“**10**” = DWC-10 Pharmacy Billing Form

“**11**” = DWC-11 Dental Claim Form

“**90**” = DWC-90 Hospital Claim Form

“**\_**” There must be an underscore immediately following the Form Type in the file name.

“**YYYYMMDD**” = The Year, Month, and Day of the file submission.

“**\_**” **There must be an underscore immediately following the submission date in the file name.**

“**HHMMSS**” = **The Hour, Minute, and Seconds of the file submission, making the file name unique, just in case you have multiple files being transmitted in quick succession.**

“**Z**” = Test / Production indicator. Use “T” for a Test file and “P” for a Production file.

“**.TXT**” = All files must end with a .TXT extension.

# APPENDIX K

## Dispense as Written (DAW) Codes

(Form DFS-5-DWC-10)

- 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

# DOCUMENTS

# MEDICAL

## New Submitter Specifications

Submitter Name: \_\_\_\_\_ FEIN: \_\_\_\_\_

The submitter shall complete and send this form to the division at least two weeks prior to sending the initial test transmission.

1. **Purpose.** For purposes of this document, a submitter is an insurer, vendor or service co/TPA that is using Electronic Data Interchange (EDI) to exchange workers' compensation medical data with the Florida Division of Workers' Compensation (DWC). The submitter shall refer to the Florida Medical EDI Implementation Guide, 2007 (MEIG) when sending electronic form equivalents of division medical forms.

2. **Format.** Data shall be submitted using the DWC form file layouts contained in the MEIG.

3. **Transmission Costs.** The submitter shall pay all transmission costs related to sending medical EDI data to the division. The division shall bear the cost of sending medical EDI transmission acknowledgments to the submitter.

4. **Filing Volume and Frequency.** Indicate the estimated volume of filings per form type and frequency.

EDI DFS-F5-DWC-09 filings:	_____	per	Week <input type="checkbox"/>	Month <input type="checkbox"/>
EDI DFS-F5-DWC-10 filings:	_____	per	Week <input type="checkbox"/>	Month <input type="checkbox"/>
EDI DFS-F5-DWC-11 filings:	_____	per	Week <input type="checkbox"/>	Month <input type="checkbox"/>
EDI DFS-F5-DWC-90 filings:	_____	per	Week <input type="checkbox"/>	Month <input type="checkbox"/>

5. **Test Start Date.** Specify the target date for sending test transmissions: \_\_\_\_\_

6. **Contact Person(s) for EDI Test and Production Phases.** Provide the name, phone number, and e-mail address for all persons to whom EDI test and production communications should be sent (i.e., Transmission Receipt Confirmations and Medical Claim Processing Reports). To add additional contacts please use the Submitter Contact Update form.

Contact Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Contact Type: Business  Technical  Both

Please select notification preferences:

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

Contact Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Contact Type: Business  Technical  Both

Please select notification preferences:

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

7. **Virus Software Used (Required)** \_\_\_\_\_

# MEDICAL

## Submitter Contact Update

Submitter Name: \_\_\_\_\_

ID #: \_\_\_\_\_

**Additional Contact Person(s):** Provide the following information for all persons to whom EDI test and production communications should be sent (i.e., Transmission Receipt Confirmations and Medical Claim Processing Reports).

**Contact Name:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

**Contact Name:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

**Contact Name:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

**Contact Name:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

- File Receipt Acknowledgement  Global Emails  
 Claim Processing Reports  Monthly Report Cards  
 Outstanding Rejected Claims Report

**Delete the Following Contact(s):** Provide the name of the contact to be removed from any future test or production communication.

**Contact Name:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_

