



## FORM DFS-F5-DWC-10

### COMPLETION INSTRUCTIONS

**SECTION 1** – Fields 1-5 required to be completed by Pharmacy and Medical Supply providers:

1. Employee's Name - Enter the injured employee's name: Last, First and Middle Initial, if applicable.
2. Soc. Sec. or Division-Assigned Number - Enter the injured employee's social security or division-assigned number. Contact the insurer/carrier to obtain the division-assigned identification number if unknown and if there is no known social security number.
3. Date of Accident - Enter the date of current accident, injury or illness in MM/DD/CCYY format.
4. Insurer/Carrier Name, Address & Telephone Number - Complete if not self-insured.
5. Employer's Name & Address - Enter the name, address, and zip code of employer.

**SECTION 2** - Fields 6-15 required to be completed by Pharmacy Providers ONLY:

6. Medication & Strength - Enter the medication/drug name and strength.
7. Quantity - Enter the number of tablets, capsules, suppositories, milliliters of liquid, grams of ointment or units of injectable medication.
8. Days Supply - Enter the estimated number of days that medication will last according to prescription's dosage and administration instructions.
9. NDC - Enter the National Drug Code number: Manufacturer Code, Item Code and Package Code or enter the unique workers' compensation code 96371 if the prescription dispensed is not commercially available and is compounded by a pharmacist.
10. RX Number - Enter the provider's internal number assigned to the prescription, if applicable.
11. New/Refill - Check one box: "new" or "refill" prescription.
12. Date Filled - Enter the date in MM/DD/CCYY format.

13. Certification - Enter one of the following codes:

“1” when the ordering health care provider indicates a “brand name drug medically necessary”; OR

“2” if the brand name drug has no generic equivalent; OR

“3” when the patient insists on the brand name drug AND agrees to pay the cost difference between the generic and the brand name drug; OR

“4” when the generic equivalent or a compounded drug is dispensed.

14. Prescriber’s FL Dept. of Health (DOH) License # - Enter the ordering health care provider’s license number, as assigned by the Florida Department of Health. Out of state providers enter ZZ999999999999.

15. Usual Charge - Enter the usual charge for the drug. When Field 13 is coded “3”, enter the usual charge for the generic equivalent.

**SECTION 3** – Fields 16-19 required to be completed by Medical Supplier or Pharmacy providing medical supplies:

16. Description of Medical Supply - Enter the name of the item(s) as well as the quantity and size when applicable.

17. Prescriber’s FL DOH License # - Enter the ordering health care provider’s license number as assigned by the Florida Department of Health. Out of state providers enter ZZ999999999999.

18. Purchase Date - Enter the date of purchase in MM/DD/CCYY format.

19. Usual Charge - Enter the provider’s usual charge for the item(s) supplied.

**SECTION 4** - Fields 20-25 to be completed by Pharmacy providers.

Fields 20-22 and 24-25 to be completed by Medical Supply providers.

Fields 26 and 27 to be completed by Insurer/Carriers.

20. Total Charges This Statement - Enter the total charges appearing on this statement, ONLY.

21. Name and Address of Pharmacy or Medical Supplier - Enter the provider's name and address.
22. Date of This Statement - Enter the date the provider submits this statement to the insurer/carrier for payment in MM/DD/CCYY format.
23. Pharmacist's License # - Enter the pharmacist's license number assigned by professional regulatory board or licensing authority.
24. Provider Federal Employer Identification Number - Enter the Federal Employer Identification Number (FEIN) of the pharmacy or medical supplier.
25. Name of Pharmacist or Medical Supplier - For pharmacy claims, the pharmacist's name must appear on the statement. For medical supplier claims, the authorized billing person's name must appear on the statement.

**FOR INSURER/CARRIER USE**

26. Total Reimbursed from Section 2 - Insurer/Carrier to enter the total amount reimbursed by the insurer/carrier in Section 2.
27. Total Reimbursed from Section 3 - Insurer/Carrier to enter the total amount reimbursed by the insurer/carrier in Section 3.