*THESE FORMS ARE FICTIONAL AND ANY RELATION TO A REAL PERSON IS COINCIDENTAL

DATE RECEIVED: 06/07/2009
DATE PAID: 06/15/2009
(Durable Medical Equipment Scenario)

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION

STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.
For Drug Products - Complete sections 1, 2 & 4 For Supplies & Equipment - Complete sections 1, 3 & 4

SECTION I

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #
MICHAEL A MOUSE	023456701

3. DATE OF ACCIDENT	4. EMPLOYEE'S DOB	5. GENDER	6. CLAIMS-HANDLING ENTITY INTERNAL FILE #
05/30/2009	01/12/1945	MALE ☐ FEMALE ☐	555-0245M

7. INSURER/CARRIER NAME & ADDRESS	8. EMPLOYER'S NAME & ADDRESS

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE	19b. RENTAL DATE	20. USUAL CHARGE
Bath/Shower Chair	06/05/2009		$ 28.68

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #
E0240	1	Physician Name, MD	ME652199

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE	19b. RENTAL DATE	20. USUAL CHARGE
Cane	06/05/2009		$ 55.03

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #
E0100	1	Physician Name, MD	ME652199

SECTION 4

24. NAME OF PHARMACY OR MEDICAL SUPPLIER	25. REMITTANCE RECIPIENT'S FEIN #
Durable Medical Equipment,Inc.	59-3425678

26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	27. REMITTANCE ADDRESS (if different from Field 26.) Check if Same [X]
17000 NW 3RD AVE Miami, FL 33169	

28. NAME OF PHARMACIST OR MEDICAL SUPPLIER	29. PHARMACIST'S FLORIDA DEPARTMENT OF HEALTH LICENSE #
	DME2312223

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2	31. TOTAL REIMBURSEMENT FROM SECTION 3
$ 0.00	$ 83.71

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

REVISION E DWC-10 TEST BILL

*THESE FORMS ARE FICTIONAL AND ANY RELATION TO A REAL PERSON IS COINCIDENTAL

DATE RECEIVED: 10/25/2009
DATE PAID: 10/30/2009

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION

STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.

For Drug Products - Complete sections 1, 2 & 4 **For Supplies & Equipment - Complete sections 1, 3 & 4**

SECTION I

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #
YOLANDA WHITE	023456702

3. DATE OF ACCIDENT	4. EMPLOYEE'S DOB	5. GENDER	6. CLAIMS-HANDLING ENTITY INTERNAL FILE #
05/02/2009	05/18/1953	MALE ☐ FEMALE ☒	666-55545

7. INSURER/CARRIER NAME & ADDRESS	8. EMPLOYER'S NAME & ADDRESS

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
00186-1092-05	30	30	TOPROL, XI 95	$ 42.66

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
1525818 new ☐ refill ☒	4	09/14/2009	PHYSICIAN NAME, MD	ME652202

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
00006-0717-31	30	30	HYZAAR	$ 56.27

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
1525820 new ☐ refill ☒	2	09/14/2009	PHYSICIAN NAME, MD	ME652202

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
		$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
		$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

SECTION 4

24. NAME OF PHARMACY OR MEDICAL SUPPLIER	25. REMITTANCE RECIPIENT'S FEIN #
MCCALL DRUGS	59-1234567

26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	27. REMITTANCE ADDRESS (if different from Field 26.) Check if Same ☐
100 N. INTERNATIONAL FREEWAY TALLAHASSEE, FL 32308	1726 FRANKLIN STREET TALLAHASSEE, FL 32303

28. NAME OF PHARMACIST OR MEDICAL SUPPLIER	29. PHARMACIST'S FLORIDA DEPARTMENT OF HEALTH LICENSE #
	PS52522

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2	31. TOTAL REIMBURSEMENT FROM SECTION 3
$ 98.93	$

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

REVISION E DWC-10 TEST BILL

*THESE FORMS ARE FICTIONAL AND ANY RELATION TO A REAL PERSON IS COINCIDENTAL

DATE RECEIVED: 10/20/2009
DATE PAID: 10/30/2009

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION

STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.
For Drug Products - Complete sections 1, 2 & 4 For Supplies & Equipment - Complete sections 1, 3 & 4

SECTION I

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #
KATRINA ALEXANDER	023456703

3. DATE OF ACCIDENT	4. EMPLOYEE'S DOB	5. GENDER	6. CLAIMS-HANDLING ENTITY INTERNAL FILE #
05/25/2009	07/04/1957	MALE ☐ FEMALE ☒	000254ALE

7. INSURER/CARRIER NAME & ADDRESS	8. EMPLOYER'S NAME & ADDRESS

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
0 0 0 8 5 - 0 5 6 7 - 0 1	30	3	ELOCON, 1 mg.	$ 63.68

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
1113747 new ☐ refill ☒	8	08/31/2009	Physician's Name	ME652202

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new ☐ refill ☐				

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
		$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
		$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

SECTION 4

24. NAME OF PHARMACY OR MEDICAL SUPPLIER	25. REMITTANCE RECIPIENT'S FEIN #
MCCALL DRUGS	59-1234567

26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	27. REMITTANCE ADDRESS (if different from Field 26.) Check if Same ☒
100 N. INTERNATIONAL FREEWAY TALLAHASSEE, FL 32308	

28. NAME OF PHARMACIST OR MEDICAL SUPPLIER	29. PHARMACIST'S FLORIDA DEPARTMENT OF HEALTH LICENSE #
	PS52522

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2	31. TOTAL REIMBURSEMENT FROM SECTION 3
$ 63.68	$

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

REVISION E DWC-10 TEST BILL

*THESE FORMS ARE FICTIONAL AND ANY RELATION TO A REAL PERSON IS COINCIDENTAL

DATE RECEIVED: 11/25/09
DATE PAID: 11/26/09
(Compound Drug Scenario)

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION

STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.

For Drug Products - Complete sections 1, 2 & 4 For Supplies & Equipment - Complete sections 1, 3 & 4

SECTION I

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #
MICHAEL ALBRIGHT	023456704

3. DATE OF ACCIDENT	4. EMPLOYEE'S DOB	5. GENDER	6. CLAIMS-HANDLING ENTITY INTERNAL FILE #
11/01/09	01/12/1945	MALE [X] FEMALE [ ]	4445558-A

7. INSURER/CARRIER NAME & ADDRESS	8. EMPLOYER'S NAME & ADDRESS

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
59011-0100-10	60	30	OXYCONTIN, 1OMG TABLETS	$ 114.96

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
620436 new [X] refill [ ]	8	11/20/2009	MEDICAL DOCTOR, MD	ME652199

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
COMPD-0000-00	1	10	Compound Drug	$ 68.07

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
620464 new [X] refill [ ]	5	11/20/2009	MEDICAL DOCTOR, MD	ME652199

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
- -				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
new [ ] refill [ ]				

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
WHEELCHAIR	19a. / 19b. 11/20/09-11/23/09	$ 500.00

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #
E1086	1	MEDICAL DOCTOR, MD	ME652199

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE / 19b. RENTAL DATE	20. USUAL CHARGE
		$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

SECTION 4

24. NAME OF PHARMACY OR MEDICAL SUPPLIER	25. REMITTANCE RECIPIENT'S FEIN #
	59-9874561

26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	27. REMITTANCE ADDRESS (if different from Field 26.) Check if Same [X]
1745 W. PENSACOLA, ST TALLAHASSEE, FL 32304	

28. NAME OF PHARMACIST OR MEDICAL SUPPLIER	29. PHARMACIST'S FLORIDA DEPARTMENT OF HEALTH LICENSE #
	PS52525

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2	31. TOTAL REIMBURSEMENT FROM SECTION 3
$ 183.03	$ 500.00

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

REVISION E DWC-10 TEST BILL

*THESE FORMS ARE FICTIONAL AND ANY RELATION TO A REAL PERSON IS COINCIDENTAL

DATE RECEIVED: 09/24/2009
DATE PAID: 09/26/2009

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION

STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services.
For Drug Products - Complete sections 1, 2 & 4 For Supplies & Equipment - Complete sections 1, 3 & 4

SECTION I

Field	Value
1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	WILLIAM TELL
2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #	023456709
3. DATE OF ACCIDENT	09/20/09
4. EMPLOYEE'S DOB	05/16/1973
5. GENDER	MALE [X] FEMALE [ ]
6. CLAIMS-HANDLING ENTITY INTERNAL FILE #	554876T-05
7. INSURER/CARRIER NAME & ADDRESS	
8. EMPLOYER'S NAME & ADDRESS	

SECTION 2 PRESCRIPTION DRUGS

9. NDC# (5-4-2 format)	10. QUANTITY	11. DAYS	12. MEDICATION & STRENGTH	13. USUAL CHARGE
45802-0119-42	45	6	MOMETASONE FUR. Oint. 0.1%	$ 48.78
				$
				$

14. RX #	15. DAW CODE	16. DATE FILLED	17a. PRESCRIBER'S NAME	17b. FL. DOH LICENSE #
1140234 new [X] refill [ ]	5	09/20/2009		ME652199
new [ ] refill [ ]				
new [ ] refill [ ]				

SECTION 3 MEDICAL EQUIPMENT & SUPPLIES

18. DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	19a. PURCHASE DATE	19b. RENTAL DATE	20. USUAL CHARGE
			$
			$

21. HCPCS CODE	22. QUANTITY	23a. PRESCRIBER'S NAME	23b. FL DOH LICENSE #

SECTION 4

Field	Value
24. NAME OF PHARMACY OR MEDICAL SUPPLIER	
25. REMITTANCE RECIPIENT'S FEIN #	59-9874561
26. PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	1745 W. PENSACOLA,ST TALLAHASSEE, FL 32304
27. REMITTANCE ADDRESS (if different from Field 26.)	Check if Same [X]
28. NAME OF PHARMACIST OR MEDICAL SUPPLIER	
29. PHARMACIST'S FLORIDA DEPARTMENT OF HEALTH LICENSE #	PS52525

FOR INSURER/CARRIER USE

30. TOTAL REIMBURSEMENT FROM SECTION 2	31. TOTAL REIMBURSEMENT FROM SECTION 3
$ 48.78	$

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Form DFS-F5-DWC-10
Rev. 1/1/2007

REVISION E DWC-10 TEST BILL