DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-11-A (ADA FORM J430D) COMPLETION INSTRUCTIONS FOR DENTISTS				
DENTIST AND DENTAL PROVIDERS SHALL COMPLETE THE DFS-F5-DWC-11 (ADA DENTAL CLAIM FORM) ACCORDING TO THESE INSTRUCTIONS AND THE COMPREHENSIVE ADA DENTAL CLAIM FORM COMPLETION INSTRUCTIONS. DENTAL PROVIDERS SHALL ENTER INSURER/CLAIM ADMINISTRATOR NAME, ADDRESS, AND ZIP CODE IN THE BLANK AREA ON TOP OF THE DWC-11.				
FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
A. HEADER INFORMATION – FIELDS 1 AND 2				
1.	TYPE OF TRANSACTION	REQUIRED	Enter and "X" in the box indicating "Statement of Actual Services".	NO
2.	PREDETERMINATION/ PREAUTHORIZATION NUMBER	NOT REQUIRED	Optional for completion. Provider's who choose to complete this field may enter the insurer/carrier prior authorization number.	NO
B. INSURANCE COMPANY/DENTAL BENEFITS PLAN INFORMATION – FIELD 3				
3.	COMPANY/PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE	REQUIRED	Enter injured employee's last name, first name, and middle initial, if applicable.	NO
C. OTHER COVERAGE – FIELDS 4-11				
4	OTHER DENTAL OR MEDICAL COVERAGE	NOT REQUIRED		NO
5	NAME OF POLICYHOLDER/ SUBSCRIBER IN #4	NOT REQUIRED	.	NO

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6	DATE OF BIRTH	NOT REQUIRED		NO
7.	GENDER	NOT REQUIRED		NO
8	POLICYHOLDER/ SUBSCRIBER ID (SSN OR ID#)	REQUIRED	Enter the injured employee's Social Security Number or Division-Assigned Number. If there is no known Social Security Number or if the Division-Assigned Number is unknown, the health care provider must contact the WC Insurer/Claim Administrator to obtain the number.	YES
9.	PLAN/ GROUP NUMBER	NOT REQUIRED		NO
10.	PATIENT'S RELATIONSHIP TO PERSON NAMED IN #5	NOT REQUIRED		NO
11.	OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE	NOT REQUIRED		NO

D. POLICYHOLDER/SUBSCRIBER INFORMATION – FIELDS 12-17

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12.	POLICYHOLDER/ SUBSCRIBER NAME, ADDRESS, CITY, STATE, ZIP CODE	REQUIRED	Enter the name, address, and zip code of the employer of the injured employee on the date entered in Field 46.	NO
13.	DATE OF BIRTH	NOT REQUIRED		NO
14.	GENDER	NOT REQUIRED		NO
15.	POLICYHOLDER/ SUBSCRIBER ID	NOT REQUIRED		NO
16.	PLAN/GROUP NUMBER	NOT REQUIRED		NO
17.	EMPLOYER NAME	NOT REQUIRED		NO
E. PATIENT INFORMATION – FIELDS 18-23				
18.	RELATIONSHIP TO POLICYHOLDER/ SUBSCRIBER IN #12 ABOVE	NOT REQUIRED		NO
19.	RESERVED FOR FUTURE USE	NOT REQUIRED		NO

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20.	NAME, ADDRESS, CITY, STATE, ZIP CODE	REQUIRED	Enter the injured employee's last name, first name and middle initial, if applicable.	NO
21.	DATE OF BIRTH	REQUIRED	Enter the injured employee's date of birth in MM/DD/YYYY format.	NO
22.	GENDER	REQUIRED	Enter the injured employee's gender by entering an 'X' in one box: "M" = male or "F" = female.	NO
23.	PATIENT ID/ACCOUNT #	NOT REQUIRED		NO
F. RECORD OF SERVICES PROVIDED – FIELDS 24-32				
24.	PROCEDURE DATE	REQUIRED	Enter the date of service in MM/DD/YYYY format. If multiple dates are involved, e.g. root canal therapy and prosthesis enter the preparation date/impression date/opening date of canal and the completion or seating date.	YES
25.	AREA OF ORAL CAVITY	NOT REQUIRED		NO
26.	TOOTH SYSTEM	NOT REQUIRED		NO

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27.	TOOTH NUMBER(S) OR LETTER(S)	CONDITIONAL	Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen (“-”) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.	NO
28.	TOOTH SURFACE	CONDITIONAL	Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B = Buccal; D= Distal; F = Facial; L = Lingual; M = Mesial; and O = Occlusal.	NO
29.	PROCEDURE CODE	REQUIRED	Enter the valid CDT, CPT®, or DSPNS.	NO
29a.	DIAG. POINTER	CONDITIONAL	Enter the letter(s) from Field 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.	NO
29b.	QTY	REQUIRED	Enter the number of times (01-99) the procedure identified in item 29 is delivered to the patient on the date of service shown in item 24. The default value is “01”.	NO
30.	DESCRIPTION	REQUIRED	Enter the description of the service rendered or the NDC Number for the dispensed drug(s) .	NO
31.	FEE	REQUIRED	Enter the health care provider’s usual charge, in dollar and cent format, for the procedure reported on each line when a procedure code is entered in Field 29. Do not use special characters, i.e., dollar signs ($) or decimal points (.) when reporting charges. If multiple units are billed, enter the total charge by multiplying the units of service times the charge per unit.	NO
31a.	OTHER FEE(S)	NOT REQUIRED		NO

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
32.	TOTAL FEE	REQUIRED	Enter the total of all charges listed in Field 31using dollar and cent format. Do not use special characters, i.e., dollar signs ($) or decimal points (.) when reporting charges. Total each page separately if multiple Form DFS-F5-DWC-11 (ADA Dental Claim Form) claim forms are submitted for the same injured employee for the same date of service.	NO
G. MISSING TEETH INFORMATION – FIELDS 33 AND 35				
33.	MISSING TEETH INFORMATION	CONDITIONAL	Completion of this field is only necessary for identifying missing permanent dentition only. Mark and “X” on the number of the missing tooth.	NO
34.	DIAGNOSIS CODE LIST QUALIFIER	CONDITIONAL	Completion of this field is required if Field 29a is completed. Enter the appropriate code to identify the diagnosis code source.	NO
34a.	DIAGNOSIS CODE(S)	CONDITIONAL	Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter “A”. NOTE: ICD-9 shall be used for dates of service prior to the 10/01/2015 federal implementation date for the use of the ICD-10. ICD-10 shall be used for dates of service on or after the 10/01/2015 federal implementation date.	NO
35.	REMARKS	NOT REQUIRED		NO
H. AUTHORIZATIONS – FIELDS 36 AND 37				

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36.	UNNAMED (EMPLOYEE SIGNATURE)	NOT REQUIRED	·	NO
37.	UNNAMED (Subscriber Signature)	NOT REQUIRED		NO
I. ANCILLARY CLAIM/TREATMENT INFORMATION – FIELDS 38-47				
38.	PLACE OF TREATMENT	REQUIRED	Enter the appropriate 2-digit place of treatment code from list: 11, 12, 21, 22, 23, 31, 32, or 99 only.	NO
39.	ENCLOSURES (Y OR N)	REQUIRED	Enter “Y” or “N” in the provided box to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).	NO
40.	IS TREATMENT FOR ORTHODONTICS?	REQUIRED	Enter an “x” in the appropriate box: “No” or “Yes”. If “No” is entered, skip Fields 41-42. If “Yes” is entered, complete Fields 41-42.	NO
41.	DATE APPLIANCE PLACED	CONDITIONAL	Complete this field if Field 40 is checked “Yes”. Enter the date in MM/DD/YYYY format.	NO
42.	MONTHS OF TREATMENT	CONDITIONAL	Complete this field if Field 40 is checked “Yes”. Enter the total number of months remaining to complete treatment, if applicable.	NO
43.	REPLACEMENT OF PROSTHESIS	REQUIRED	Enter and “X” in the appropriate box: “No” or “Yes”.	NO

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44.	DATE OF PRIOR PLACEMENT	CONDITIONAL	Complete this field only if Field 43 is checked "Yes". Enter the date in MM/DD/YYYY format.	NO
45.	TREATMENT RESULTING FROM	REQUIRED	Enter an "x" in the appropriate box(es): "Occupational Illness/Injury" if the billed services are for a condition covered by workers' compensation insurance, "Auto Accident" if the billed services are for a condition related to an automobile accident, "Other Accident" if the billed services are for a condition related to any type of accident other than an automobile accident or employment.	NO
46.	DATE OF ACCIDENT	REQUIRED	Enter the date of the work related accident, injury or illness in MM/DD/YYYY format.	NO
47.	AUTO ACCIDENT STATE:	NOT REQUIRED		NO
J. BILLING DENTIST – FIELDS 48-52A				
48.	NAME, ADDRESS, CITY, STATE, ZIP CODE	REQUIRED	Enter the name, address and zip code of the health care provider or entity to which payment is due.	NO
49.	NPI:	NOT REQUIRED		NO
50.	LICENSE NUMBER	NOT REQUIRED		NO

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51.	SSN OR TIN	REQUIRED	Enter the federal tax identification number of the dentist or entity to which payment is to be rendered. The entry will be either a Social Security Number or a Tax Identification Number.	YES
52.	PHONE NUMBER	NOT REQUIRED		NO
52a.	ADDITIONAL PROVIDER ID	NOT REQUIRED		NO
K. TREATING DENTIST AND TREATING LOCATION INFORMATION – FIELDS 53-58				
53.	SIGNATURE (TREATING DENTIST)	REQUIRED	Enter the name of the dentist who rendered the direct billable services. THE DENTIST'S NAME AND LICENSE NUMBER (FIELD 55) MUST AGREE.	NO
54.	NPI	NOT REQUIRED		NO
55.	LICENSE NUMBER	REQUIRED	Enter the dentist's alpha-numeric license number as assigned by the Florida Department of Health. Out-of-state dentists, enter the WC unique license number "ZZ99999999999".	NO
56.	ADDRESS, CITY, STATE, ZIP CODE	REQUIRED	Enter the name, address, and zip code of the physical location where the dentist rendered the direct billable service(s).	NO
56a.	PROVIDER SPECIALTY CODE	NOT REQUIRED		NO

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57.	PHONE NUMBER	NOT REQUIRED		NO
58.	ADDITIONAL PROVIDER ID	NOT REQUIRED		NO