DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-9-A COMPLETION INSTRUCTIONS FOR PHYSICIANS AND RECOGNIZED PRACTITIONERS				
PHYSICIANS AND RECOGNIZED PRACTITIONERS SHALL COMPLETE THE DWC-9 ACCORDING TO THESE INSTRUCTIONS AND SHALL ENTER THE INSURER/CLAIMS ADMINISTRATOR NAME, ADDRESS, AND ZIP CODE IN THE BLANK AREA ON TOP OF THE DWC-9 (CMS-1500)				
FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
1.	TYPE OF CLAIM	NOT REQUIRED		NO
1a.	INSURED'S I.D. NUMBER	REQUIRED	Enter the Social Security Number or the Division-Assigned Number of the injured employee. If the Social Security Number is unknown and the Division-Assigned Number is also unknown, the provider must contact the insurer/claim administrator to obtain the number.	YES
2.	PATIENT'S NAME	REQUIRED	Enter injured employee's last name, first name, and middle initial, if applicable.	NO
3.	PATIENT'S BIRTH DATE AND SEX	REQUIRED	Enter injured employee's date of birth in MMDDYY format, and sex (M or F).	NO

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4.	INSURED'S NAME	REQUIRED	Enter the business name for the injured employee's employer on the date entered in Field 14.	NO
5.	PATIENT'S ADDRESS	REQUIRED	Enter the injured employee's complete mailing address and telephone number in the appropriate spaces: Line 1 – Enter the street address, including apartment number if applicable; Line 2 – Enter the city and state; Line 3 – Enter the zip code and telephone number including area code.	NO
6.	PATIENT RELATIONSHIP TO INSURED	NOT REQUIRED		NO
7.	INSURED'S ADDRESS	REQUIRED	Enter the complete business address of the employer entered in Field 4: Line 1 – Enter the street address, including suite number if applicable; Line 2 – Enter the city and state; Line 3 – Enter the zip code and telephone number.	NO
8.	RESERVED FOR NUCC USE	NOT REQUIRED		NO
9.	OTHER INSURED'S NAME	NOT REQUIRED		NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER	NOT REQUIRED		NO
9b.	RESERVED FOR NUCC USE	NOT REQUIRED		NO
9c.	RESERVED FOR NUCC USE	NOT REQUIRED		NO
9d.	INSURANCE PLAN NAME OR PROGRAM NAME	NOT REQUIRED	Completion of this field is optional. Provider may enter the insurer's/claim administrator's telephone number including area code.	NO
10.	IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT B. AUTO ACCIDENT C. OTHER ACCIDENT	REQUIRED (A, B.,C.)	Enter an "x" in the appropriate box (A,B,C) to indicate whether any of the billed services are for a condition covered by workers' compensation insurance, an auto accident, or any other accident type.	NO
10d.	CLAIM CODES (DESIGNATED BY NUCC)	CONDITIONAL	Enter Claim Codes as applicable.	NO
11.	INSURED'S POLICY GROUP OR FECA NUMBER	NOT REQUIRED		NO
11a.	INSURED'S DATE OF BIRTH AND SEX	NOT REQUIRED		NO

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11b.	OTHER CLAIM ID (DESIGNATED BY NUCC)	NOT REQUIRED		NO
11c.	INSURANCE PLAN NAME OR PROGRAM NAME	NOT REQUIRED		NO
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	NOT REQUIRED		NO
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	NOT REQUIRED		NO
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	NOT REQUIRED		NO
14.	DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)	REQUIRED	Enter the date of onset, in MMDDYY, i.e. date of first symptom or current accident, illness or injury.	NO
15.	OTHER DATE	NOT REQUIRED		NO
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	NOT REQUIRED		NO

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17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	NOT REQUIRED		NO
17a.	UNNAMED	CONDITIONAL	Enter the Florida Department of Health alpha-numeric license number of the referring health care provider, if available.	NO
17b.	NPI	NOT REQUIRED		NO
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	CONDITIONAL	Enter “FROM” and “TO” dates, in MMDDYY format, when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	NO
19.	ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)	CONDITIONAL	Enter the word “ATTACHMENTS” If the claim form is accompanied by attachments(s) (e.g., documentation of supply costs, medical records, etc.).	NO
20.	OUTSIDE LAB	NOT REQUIRED		NO

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21.	ICD IND.	REQUIRED	Enter the applicable ICD indicator to identify which version of ICD codes are being reported: 9=ICD-9 0=ICD-10. 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. (ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER.)	YES
21. A-L	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE A-L TO SERVICE LINE BELOW (24E)	REQUIRED	Enter the ICD diagnosis code. When more than one diagnosis is identified and multiple ICD codes are used, the code representing the primary diagnosis **must be listed first** in field 21(A). Enter additional diagnosis codes (ICD) in fields 21(A) through 21(L). 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. (ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER.)	YES
22.	RESUBMISSION CODE	CONDITIONAL	This field is required if the bill is not an initial bill. 7= Replacement of prior claim 8= Cancellation or void of prior claim	NO

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23.	PRIOR AUTHORIZATION NUMBER	CONDITIONAL	Completion of this field is optional. Provider may enter the insurer/carrier's prior authorization number, if available.	NO
24	UNNAMED (Upper Level Shaded Area)	CONDITIONAL	Required if procedure code in field 24D is DSPNS. When the dispensed medication is NOT repackaged/relabeled medication, enter the 11 digit Original NDC Number (5 4 2 format) preceded by the alpha-numeric qualifier "N4" in the shaded area of Field 24. When the dispensed drug is a repackaged/relabeled drug, report the information in the shaded area of 24 in the following order: the alpha-numeric qualifier "N4", 11-digit Repackaged NDC Number (5 4 2 format), "ORIG", qualifier "N4", 11-digit Original NDC Number (5 4 2 format).	NO
24A.	DATE(S) OF SERVICE	REQUIRED	Claim detail line. Enter the "FROM" and "TO" date of service in MMDDYY format. Multiple dates of service may be billed on a single line ONLY if the dates of service are consecutive and occur within the same month. For example: April 30, May 1, 2, and 3, 2004 Line 1=043004 Line 2=050104 050304 If only a single date is applicable, enter the same date in the "FROM" and "TO" fields.	YES
24B.	PLACE OF SERVICE	REQUIRED	Claim detail line. Enter the appropriate 2-digit numeric place of service code as identified in the Current Procedural Terminology (CPT) Manual.	NO

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24C.	EMG	REQUIRED	Claim detail line. Enter a "Y" for yes or "N" for no in this field to indicate if emergency care was provided.	NO
24D.	PROCEDURES, SERVICES OR SUPPLIES	REQUIRED	Claim detail line. Enter the valid CPT, CDT, HCPCS or unique workers' compensation procedure code in the first section of Field 24D (under CPT/HCPCS). Enter "DSPNS" for each line item for which an NDC number(s) is listed in the shaded area of Field 24. Enter "COMPD" if the prescription dispensed is compounded by the physician and not commercially available. When required or appropriate, enter a 2-character modifier in the second section of Field 24D (under MODIFIER). See Rule 69L-7.730(2), F.A.C., special billing instructions for anesthesia services. NOTE: THE INSURER/CLAIM ADMINISTRATOR MUST NOT CHANGE OR MARK THROUGH THE ORIGINAL PROCEDURE CODE OR MODIFIER AS ENTERED BY THE HEALTH CARE PROVIDER.	NO
24E.	DIAGNOSIS POINTER	REQUIRED	Claim detail line. Enter the diagnosis reference letter(s) (A through L) from Field 21 to relate the date of service and procedures performed to the appropriate diagnosis. Up to four reference codes may be entered for each procedure code, as appropriate. Example: ABCD, KL, BDG	NO

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24F.	$ CHARGES	REQUIRED	Claim detail line. Enter the health care provider's usual charge, in dollar and cent format, for the procedure reported on each line when a procedure code is entered in Field 24D. If multiple units are billed, enter the total charge by multiplying the units of service times the charge per unit. NOTE: THE INSURER/CLAIM ADMINISTRATOR MUST NOT CHANGE OR MARK THROUGH THE CHARGE AMOUNT ENTERED BY THE HEALTH CARE PROVIDER.	NO
24G.	DAYS OR UNITS	REQUIRED	Claim detail line. Enter the number(s) in Field 24G to represent the total number of units of services/supplies rendered. Enter all units of service that specify time in hours and quarter hours. For example, if the time required were two hours and fifteen minutes, the entry on the claim form would be 2.25 units; one hour would be entered as 1 unit, etc.	NO
24H.	EPSDT FAMILY PLAN	NOT REQUIRED		NO
24I.	ID QUAL	NOT REQUIRED		NO
24J.	RENDERING PROVIDER ID #	NOT REQUIRED		NO
25.	FEDERAL TAX I.D. NUMBER	REQUIRED	Enter the tax identification number of the health care provider or entity to which payment is due. Enter an "x" in the appropriate box to indicate if the number is a Federal Employer Identification Number (FEIN) or a social security number SSN). Do not use special characters, e.g. periods (.), dashes (-), etc.	YES

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26.	PATIENT ACCOUNT NO.	NOT REQUIRED	Completion of this field is optional. If completed, enter the injured employee's account number as recorded in the health care provider's accounting system.	NO
27.	ACCEPT ASSIGNMENT?	NOT REQUIRED		NO
28.	TOTAL CHARGE	REQUIRED	Enter the total of all charges listed in field 24F using 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-9 (CMS-1500) claim forms are submitted for the same injured employee for the same date of service.	NO
29.	AMOUNT PAID	NOT REQUIRED		NO
30.	RESERVED FOR NUCC USE	NOT REQUIRED		NO
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	REQUIRED	Enter the name of the health care provider or entity that rendered the direct billable services. THE HEALTH CARE PROVIDER'S NAME AND PERSONAL IDENTIFICATION NUMBER (FIELD 33 b) MUST AGREE.	NO
32.	SERVICE FACILITY LOCATION INFORMATION	REQUIRED	Enter the zip code of the physical location where services were rendered.	NO

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32a.	NPI	NOT REQUIRED		NO
32b.	OTHER ID#	NOT REQUIRED		NO
33.	BILLING PROVIDER INFO AND PHONE NUMBER	REQUIRED	Enter the name, address including suite number and zip code of where payment shall be made for services provided by the practitioner listed in Field 33b.	NO
33a.	NPI	NOT REQUIRED		NO
33b.	OTHER ID#	REQUIRED	Enter the professional license number of the health care provider, who is authorized to bill directly for billable services rendered pursuant to Rule 69L- 7.730(2), F.A.C.). Independent laboratories shall enter its alpha-numeric state license number preceded by IL" (i.e. IL8##########); Advanced Registered Nurse Practitioners enter "ARNP" for required alpha characters followed by a maximum of 9 numeric characters "ARNP#########"; Radiology and Other Facilities (providing only the technical component) shall enter "XX99999999999" Out-of State providers shall enter the WC unique license number "ZZ99999999999".	NO