DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-9-B COMPLETION INSTRUCTIONS FOR WORK HARDENING AND PAIN MANAGEMENT PROGRAMS

WORK HARDENING AND PAIN MANAGEMENT PROGRAM PROVIDERS SHALL COMPLETE THIS FORM IN ACCORDANCE WITH THESES INSTRUCTIONS AND SHALL ENTER INSURER/CLAIM ADMINISTRATOR NAME, ADDRESS, AND ZIP CODE IN THE BLANK AREA ON TOP OF THE DWC-9 (CMS-1500) FORM.

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 ID 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.	YES
3.	PATIENTS BIRTH DATE AND SEX	REQUIRED	Enter injured employee's date of birth in MMDDYY format, and SEX (M or F).	NO
4.	INSURED'S NAME	REQUIRED	Enter the business name for the injured employee's employer on the date entered in Field 14.	NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
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, including area code.	NO
8.	RESERVED FOR NUCC USE	NOT REQUIRED		NO
9.	OTHER INSURED'S NAME	NOT REQUIRED		NO
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER:	NOT REQUIRED		NO

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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 GENDER:	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:	REQUIRED	The injured employee or his/her authorized representative must sign and date this field or the signature must be on file with the health care provider to permit the release of any medical or other information necessary to process the claim. If the signature is on file, enter the words "Signature on File" or "SOF". If the injured employee's representative signs, the relationship to the injured employee must be indicated. When an illiterate or physically handicapped employee signs by mark (x), a witness must sign his/her name and enter his/her address next to the mark.	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 format, i.e. date of first symptom or current accident, illness or injury. (Use only qualifier 431)	NO

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15.	OTHER DATE	NOT REQUIRED		NO
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	NOT REQUIRED		NO
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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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
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 THE 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). Additional diagnosis codes (ICD) may be entered in fields 21(B) 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.	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)	NOT REQUIRED		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	
24C.	EMG	REQUIRED	Claim detail line. Enter a "Y" for yes or "N" for no in this field to indicate if the procedure was performed as an emergency.	NO

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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 the 2-character modifier, if required and when appropriate, in the second section of Field 24D (under MODIFIER). 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, DJ, BDG	NO
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

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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 ID 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
26.	PATIENT ACCOUNT NO.	NOT REQUIRED		NO
27.	ACCEPT ASSIGNMENT	NOT REQUIRED		NO

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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 or supervised 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
32a.	NPI	NOT REQUIRED		NO
32b.	OTHER ID#	NOT REQUIRED		NO

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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 health care provider listed in Field 33b.	YES
33a.	NPI	NOT REQUIRED		NO
33b.	OTHER ID#	REQUIRED	Enter the professional license number of the health care provider, authorized to render direct or supervised billable services pursuant to Rule 69L- 7.730(2), F.A.C.). Out-of State providers enter the WC unique license number ZZ99999999999.	NO