DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-90-A (UB-04) COMPLETION INSTRUCTIONS FOR HOSPITALS

HOSPITALS SHALL COMPLETE THE DFS-F5-DWC-90 (UB-04) ACCORDING TO THESE INSTRUCTIONS AND THE NATIONAL UNIFORM BILLING COMMITTEE OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL (UB-04 MANUAL), AS INCORPORATED BY REFERENCE IN RULE 69L-8.073, F.A.C., AND THE PROCEDURE SPECIFICATIONS SHOWN BELOW.

FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
1	PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER	REQUIRED	Enter the provider's name and a valid telephone number and the physical address (including zip code) of the place where services were rendered.	NO
2	PAY-TO NAME AND ADDRESS	REQUIRED	Enter the name and address where the provider listed in Field Number 1 expects payment to be remitted.	NO
3a	PATIENT CONTROL NUMBER	CONDITIONAL		NO
3b	MEDICAL/HEALTH RECORD NUMBER	CONDITIONAL	Pursuant to the UB-04 Manual.	NO
4	TYPE OF BILL	REQUIRED	Pursuant to the UB-04 Manual.	YES
5	FEDERAL TAX NUMBER	REQUIRED	Enter the Federal Tax Identification Number of the Hospital where the service is provided. Also known as the Tax ID number (TIN).	YES

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
6	STATEMENT COVERS PERIOD	REQUIRED	Enter dates of service in MMDDYY format.	YES
7	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
8a	PATIENT NAME/IDENTIFIER	REQUIRED	Enter the patient's name: last, first, and middle initial if applicable.	NO
8b	PATIENT NAME/IDENTIFIER	REQUIRED	Enter the patient's Social Security Number or Division Assigned Number.	YES
9 a-e	PATIENT ADDRESS	REQUIRED	Enter the patient's mailing address, including street address, apartment number or other identifier, city, state, and zip code.	NO
10	PATIENT BIRTHDATE	REQUIRED	Enter the patient's date of birth in MMDDYYYY format.	NO
11	PATIENT SEX	REQUIRED	Enter the sex of the patient: M=Male, F=Female U=Unknown	NO
12	ADMISSION DATE	CONDITIONAL	Required for inpatient services pursuant to the UB-04 Manual.	YES

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
13	ADMISSION HOUR	CONDITIONAL	Required for all inpatient claims pursuant to the UB-04 Manual Required for scheduled outpatient surgery and related labs and clinical services.	YES
14	ADMISSION TYPE	REQUIRED	Pursuant to the UB-04 Manual	NO
15	ADMISSION SOURCE	NOT REQUIRED		NO
16	DISCHARGE HOUR	CONDITIONAL	Required for all final bills pursuant to the UB-04 Manual.	NO
17	PATIENT DISCHARGE STATUS	REQUIRED	Pursuant to the UB-04 Manual	NO
18	CONDITION CODES	REQUIRED	Enter code “02” in Form Locator 18.	NO
19-28	CONDITION CODES	CONDITIONAL	Use of other applicable codes from the UB-04 Manual is optional (if other codes are listed, list them in alphanumeric order in Form locators 19 through 28).	NO
29	ACCIDENT STATE	NOT REQUIRED		NO

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
30	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
31	OCCURRENCE CODES AND DATES	REQUIRED	Enter code "04" and enter the date of the accident/illness/injury as MMDDYY	NO
32-34	OCCURRENCE CODES AND DATES	CONDITIONAL	Pursuant to the UB-04 Manual	NO
35-36	OCCURRENCE SPAN CODES AND DATES	NOT REQUIRED		NO
37	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
38	RESPONSIBLE PARTY NAME AND ADDRESS	REQUIRED	Enter the name and mailing address of the workers' compensation insurer/claim administrator identified in Field Number 50. Must enter name, address and zip code.	NO
39-41	VALUE CODES AND AMOUNTS	NOT REQUIRED		NO
42	REVENUE CODE	REQUIRED	Enter a four digit Revenue Code beside each service described in column 43. The first digit is a leading zero. See NUBC Manual for specific codes. After the last Revenue Code, enter "0001" corresponding with the Total Charges amount in Column 47.	YES

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
43	REVENUE DESCRIPTION	REQUIRED	Enter a brief description that corresponds to the Revenue Code in column 42.	NO
44	HCPCS/RATES/ HIPPS RATE CODES	CONDITIONAL	Pursuant to the UB-04 Manual. CPT, HCPCS, or workers compensation unique code(s) and modifier(s) required for all applicable REV codes.	NO
45	SERVICE DATE	CONDITIONAL	Required on outpatient bills, pursuant to the UB-04 Manual. Service Date: Enter the date services are provided. (Applies to Lines 1-22 only.) Use MMDDYY format. Creation Date: Enter the date in MMDDYY format that the bill is created on Line 23. This date shall be reported on all pages of the bill.	YES
46	SERVICE UNITS	REQUIRED	Pursuant to the UB-04 Manual.	NO
47	TOTAL CHARGES	REQUIRED	Enter total charges related to the revenue code for the current billing period noted in Field #6. Total charges for both covered and non-covered services.	NO
48	NON-COVERED CHARGES	NOT REQUIRED		NO
49	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO

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50	PAYER NAME	NOT REQUIRED		NO
51	HEALTH PLAN IDENTIFICATION NUMBER	NOT REQUIRED		NO
52	RELEASE OF INFORMATION CERTIFICATION INDICATOR	NOT REQUIRED		NO
53	ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR	NOT REQUIRED		NO
54	PRIOR PAYMENTS - PAYER	NOT REQUIRED		NO
55	ESTIMATED AMOUNT DUE - PAYER	NOT REQUIRED		NO
56	NATIONAL PROVIDER IDENTIFIER (NPI)	REQUIRED	Enter the NPI Number of the Hospital where services were provided.	YES
57	OTHER PROVIDER IDENTIFIER	NOT REQUIRED		NO

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
58	INSURED'S NAME	NOT REQUIRED		NO
59	PATIENT'S RELATIONSHIP TO THE INSURED	NOT REQUIRED		NO
60	INSURED'S UNIQUE IDENTIFIER	NOT REQUIRED		NO
61	(INSURED) GROUP NAME	NOT REQUIRED		NO
62	INSURANCE GROUP NUMBER	CONDITIONAL	Pursuant to the UB-04 manual.	NO
63	TREATMENT AUTHORIZATION CODES	REQUIRED	Enter authorization code, authorization or individual's name providing prior authorization for services requested.	NO
64	DOCUMENT CONTROL NUMBER (DCN)	NOT REQUIRED		NO
65	EMPLOYER NAME (OF THE INSURED)	CONDITIONAL	Pursuant to the UB-04 manual.	NO

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
66	DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD REVISION INDICATOR)	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
67	PRINCIPAL DIAGNOSIS CODE	REQUIRED	Enter the principal ICD diagnosis code describing the condition present at the time of admission or after the admission that is responsible for the admission of the patient for care. 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

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
67A-Q	OTHER DIAGNOSES CODES	CONDITIONAL	Pursuant to the UB-04 Manual. Enter the ICD diagnosis code describing the condition that co-exists at the time of admission that may affect the patient's current care. 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.)	NO
68	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
69	ADMITTING DIAGNOSIS CODE	CONDITIONAL	Pursuant to UB-04 Manual. For inpatient services enter the ICD diagnosis code describing the patient's diagnosis at the time of admission. 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.)	NO

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70a-c	PATIENT REASON DX	NOT REQUIRED		NO
71	PROSPECTIVE PAYMENT SYSTEM (PPS) CODE	NOT REQUIRED		NO
72a-c	EXTERNAL CAUSE OF INJURY (ECI) CODE	CONDITIONAL	Pursuant to the UB-04 Manual.	NO
73	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
74	PRINCIPAL PROCEDURE CODE AND DATE	CONDITIONAL	Required for inpatient when a procedure is performed. Enter the ICD procedure code describing the procedures and dates. Enter date as MMDDYY. 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.)	NO

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74a-e	OTHER PROCEDURE CODES AND DATES	CONDITIONAL	Pursuant to the UB-04 Manual. 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.)	NO
75	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
76	ATTENDING PROVIDER NAME AND IDENTIFIERS	REQUIRED	Enter the attending provider's name (Last, First) after the labeled 'Attending'. Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of State providers enter the WC unique license number "ZZ99999999999".	NO
77	OPERATING PHYSICIAN NAME AND IDENTIFIERS	CONDITIONAL	For surgery services, enter the operating provider's name (Last, First) after the block labeled 'Operating'; Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of State providers enter the WC unique license number "ZZ99999999999".	NO
78-79	OTHER PROVIDER NAMES AND IDENTIFIERS	NOT REQUIRED		NO

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FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
80	REMARKS FIELD	CONDITIONAL	**OUTPATIENT SURGERY: must indicate "SCHEDULED" OR "NON-SCHEDULED"** for all surgical services. **INPATIENT SURGERY: if billing implant services under Revenue Code 278 must indicate "IMPLANTS"** followed by the reimbursement amount calculated pursuant to rule 69L-7.501, F.A.C. **OR** submit invoice(s) pursuant to rule 69L-7.501, F.A.C.	NO
81	CODE-CODE FIELD	NOT REQUIRED		NO