DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-10-A COMPLETION INSTRUCTIONS FOR PHARMACIES AND HOME MEDICAL EQUIPMENT PROVIDERS/SUPPLIERS

PHARMACIES AND HOME MEDICAL EQUIPMENT PROVIDERS/SUPPLIERS SHALL COMPLETE THE DFS-F5-DWC-10 FORM ACCORDING TO THESE INSTRUCTIONS.

FIELD NO.	FIELD NAME	FIELD STATUS	COMMENTS	SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)
1	EMPLOYEE'S NAME	REQUIRED	Enter the injured employee's name: First, Middle Initial, if applicable, and Last	NO
2	EMPLOYEE'S SOCIAL SECURITY NUMBER OR DIVISION ASSIGNED NUMBER	REQUIRED	Enter the injured employee's Social Security or Division-Assigned Number. Contact the insurer/claim administrator to obtain the Division-Assigned Number if unknown and if there is no known Social Security Number.	YES
3	DATE OF ACCIDENT	REQUIRED	Enter the date of accident, illness or injury, for which services are rendered, in MM/DD/YYYY format.	NO
4	EMPLOYEE'S DOB	REQUIRED	Enter the injured employee's date of birth in MM/DD/YYYY format.	NO
5	GENDER	REQUIRED	Enter the injured employee's gender by checking one box: "Male" or "Female"	NO
6	CLAIMS- HANDLING ENTITY INTERNAL FILE#	NOT REQUIRED		NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
7	INSURER/CARRIER NAME & ADDRESS	REQUIRED	Enter the name, address and zip code of the insurer/claim administrator. If self-insured, enter "self-insured".	NO
8	EMPLOYER'S NAME AND ADDRESS	NOT REQUIRED		NO
SECTION 2 FIELD 9 THRU 17 MUST BE COMPLETED BY PHARMACY ONLY WHEN DISPENSING PHARMACEUTICAL PRODUCTS				
9a.	NDC NUMBER PRIMARY	REQUIRED	Enter the National Drug Code (NDC) number segmented into the universal 5-4-2 format or enter the unique workers' compensation code COMPD-0000-00 if the prescription dispensed is compounded by the pharmacist and not commercially available.	NO
9b.	NDC NUMBER SECONDARY	CONDITIONAL	If the dispensed drug is a repackaged/relabeled drug, enter the Original Manufacturer's NDC in the universal 5 4 2 format in this field.	NO
10	QUANTITY	REQUIRED	Use common billing unit language by entering the number of billing units, AND, one of the following three billing unit descriptors: "each", "ml", or "gm". Do not enter dosage forms or package descriptions such as tablet, capsule or kit.	NO
11	DAYS	REQUIRED	Enter the estimated number of days the medication will last according to prescription's dosage and administration instructions.	NO
12	MEDICATION AND STRENGTH	REQUIRED	Medication & Strength – Enter the complete medication/drug name and dosage strength, as dispensed.	NO

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13	USUAL CHARGE	REQUIRED	Enter the pharmacy's usual charge for the drug. When Field 15 is coded "2", enter the pharmacy's usual and customary charge for the generic equivalent.	NO
14	RX #	NOT REQUIRED		NO
15	DAW CODE	REQUIRED	Enter one of the following "Dispense as Written" codes, as appropriate. 0 = No product selection indicated 1 = Substitution not allowed by provider 2 = Substitution allowed- patient requested product dispensed 3 = Substitution allowed- pharmacist selected product dispensed 4 = Substitution allowed- generic drug not in stock 5 = Substitution allowed- brand drug dispensed as generic 6 = Override 7 = Substitution not allowed- brand drug mandated by law 8 = Substitution allowed- generic drug not available in marketplace	NO
16	DATE FILLED	REQUIRED	Enter the date the prescription is filled in MM/DD/YYYY format.	NO
17a	PRESCRIBER'S NAME	REQUIRED	Enter the name of the ordering health care provider.	NO

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17b	FL DOH LICENSE #	REQUIRED	Enter the ordering health care provider's license number, as assigned by the Florida Department of Health. Out-Of-State providers, enter the WC unique license number "ZZ99999999999".	NO
SECTION 3 FIELD 18 THRU 23; REQUIRED TO BE COMPLETED FOR MEDICAL EQUIPMENT AND SUPPLIES ONLY WHEN DISPENSED BY A PHARMACY OR MEDICAL SUPPLIER.				
18	DESCRIPTION OF MEDICAL EQUIPMENT OR SUPPLY	REQUIRED	Enter the name or description of the item(s) dispensed.	NO
19a	PURCHASE DATE	CONDITIONAL	Enter the date of purchase in MM/DD/YYYY format. Leave blank if the item is provided pursuant to a rental agreement.	NO
19b	RENTAL DATE	CONDITIONAL	Enter the start date of the rental period and the end date of the rental period following the word "To". Enter both dates in MM/DD/YYYY format. Leave blank if the item is purchased.	NO
20	USUAL CHARGE	REQUIRED	Enter the provider's usual charge for the item(s) purchased. Enter the provider's usual monthly rental charge for an item when reporting a Rental Date in Field 19b.	NO
21	HCPCS CODE	REQUIRED	Enter the HCPCS (CPT level II) code for the item(s).	NO
22	QUANTITY	REQUIRED	Enter the quantity and the size, when applicable.	NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
23a	PRESCRIBER'S NAME	REQUIRED	Enter the name of the ordering health care provider.	NO
23b	FL DOH LICENSE#	REQUIRED	Enter the ordering health care provider's license number as assigned by the Florida Department of Health. Out-of State providers, enter the WC unique license number "ZZ99999999999".	NO
SECTION 4 – FIELD 24 THRU FIELD 29: REQUIRED TO BE COMPLETED BY PHARMACY AND MEDICAL EQUIPMENT AND SUPPLY PROVIDERS				
24	NAME OF PHARMACY OR MEDICAL SUPPLIER	REQUIRED	Enter the provider's business name.	NO
25	REMITTANCE RECIPIENT'S FEIN#	REQUIRED	Enter the Federal Employer Identification Number (FEIN) of the pharmacy, medical supplier or entity acting on behalf of the pharmacy, medical supplier, carrier or insurer for the purpose of receiving payment from the carrier/insurer.	YES
26	PHYSICAL ADDRESS OF PHARMACY OR MEDICAL SUPPLIER	REQUIRED	Enter the address where the pharmacy or supplier is physically located, including street address, city, state and zip code.	NO
27	REMITTANCE ADDRESS	REQUIRED	Enter the mailing address where the insurer/claim administrator is instructed to send reimbursement for items included on this statement or check the "Same" box if remittance should be sent to the physical address entered in Field 26.	NO
28	NAME OF PHARMACIST OR MEDICAL SUPPLIER	NOT REQUIRED		NO

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29	PHARMACISTS' DOH LICENSE #/ MEDICAL SUPPLIERS' LICENSE #	REQUIRED	Enter the pharmacist's license number as assigned by the Florida Department of Health. Home Medical Equipment Providers/Suppliers (DME) - Enter the alpha characters 'DME' followed by the license number assigned by the Florida Agency for Health Care Administration. For out-of- state pharmacists, and DME providers, enter the WC unique license number "ZZ99999999999".	NO
FOR INSURER/CLAIM ADMINISTRATOR USE – FIELD 30 AND/OR FIELD 31: REQUIRED TO BE COMPLETED BY THE INSURER/CLAIM ADMINISTRATOR, AS APPLICABLE.				
30.	TOTAL REIMBURSEMENT FROM SECTION 2	REQUIRED	Insurer/Claim Administrator to enter the total dollar amount the insurer/carrier reimbursed to the entity identified by the FEIN number in Field 25 for items in Section 2.	NO
31.	TOTAL REIMBURSEMENT FROM SECTION 3	REQUIRED	Insurer/Claim Administrator to enter the total dollar amount the insurer/carrier reimbursed to the entity identified by the FEIN number in Field 25 for items in Section 3.	NO