DWC FORM-67
INSTRUCTIONS FOR COMPLETING THE CMS-1500

FOR PRIMARY AND ANCILLARY HEALTH CARE PROVIDERS

AND AMBULATORY SURGICAL CENTERS

Enter the insurance carrier's (IC) name and address in the upper right margin of the form, above the form name: HEALTH INSURANCE CLAIM FORM. Complete the CMS-1500 according to the DWC instructions below. "Request for Reconsideration," must be indicated on the top of the form when applicable.

NOTE: Once adopted by CMS, DWC will require the use of a National Provider Identification Number in lieu of the license information (items # 17a and 31).

When CMS instructions apply, refer to: **www.cms.hhs.gov**, **www.trailblazerhealth.com**, and/or **www.palmettogba.com**

(R)=Required, (C)=Conditional (required for certain conditions), (O)=Optional

1a. Injured employee's ID (if SSN not available, use driver's license # & jurisdiction, green card # + "ZY", visa # +"TA", or passport # + "ZZ") (R)
2. Injured employee's name (last name, first name, MI (R)
3. Injured employee's birth date and gender (R)
4. Insured employer's local name (employer at time of injury) (R)
5. Injured employee's address, city, state, ZIP& phone, if known (R)
7. Insured employer's current business address, city, state, ZIP & phone, if known (R)
8. Injured employee's marital status (O)
10. Indicate what the employee's condition is related to: (check a, b or c) (R)
11. Workers' Compensation IC claim number, if known (O)
14. Date of injury or occupational illness (R)
15. Date provider first rendered services for this injury (O)
17. Name of referring or supervising doctor (if different from #31) or ASC surgeon (C)
17a. Professional license type, number, and jurisdiction of health care provider listed in #17 (C)
18. Dates of related hospitalization (O)
19. Additional modifiers / dates / narrative / information (refer to CMS instructions) (C)
20. Use when billing for diagnostic tests (refer to CMS instructions) (C)
21. Diagnosis or nature of illness or injury coded to the highest level of specificity (up to 4 codes) (R)
23. Preauthorization, concurrent review, and/or voluntary certification number; refer to CMS instructions for CLIA/IDE or ZIP code for ambulance point of pick up (C)
24a. Dates of service: if service begins and ends on the same date enter the date in both the "from" and "to" blocks (R)
24b. Place of service code (see CMS code list / definitions) (R)
d. Procedure, service or supply code(s) (R) and if applicable, modifier(s) that may include both CMS & DWC modifiers (if more than 2 modifiers use primary modifier as 1st modifier and "99" as second modifier (e.g., XX, 99), refer to CMS instructions) (O)
e. Diagnosis code item # (relate item numbers 1, 2, 3, and/or 4 from box #21) related to the procedure, service or supply code(s) (R)
f. Charges for each procedure, service or supply (R)
g. Number of days or units for each procedure, service or supply (R)
25. Federal tax I.D., Social Security number or country's unique ID# of the entity listed in box #33, and check appropriate box(R)
28. Total charge for this bill (R)
31. Last name, first name, MI, suffix, professional license type code, license number, and jurisdiction (no spaces or hyphens e.g., MDG1440TX, PT146484OK, ASC255606TX) of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care, and the date the claim is submitted to the IC. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor. If billing for ASC facility services, enter the ASC's facility name. (R)

License Type Codes:

AC: Acupuncturist
AMB: Ambulance Services
ASC: Ambulatory Surgical Center
AU: Audiologist
NFA: Nurse First Assistant
CNS: Clinical Nurse Specialist
CPS: Clinical Psychologist
CR: Cert. Reg. Nurse Anesthetist
CSW: Clinical Social Worker
DC: Doctor of Chiropractic
DO: Doctor of Osteopathy
DP: Doctor of Podiatric Medicine
DME: Durable Medical Equipment Supplier (if no license #, use DME & jurisdiction (e.g., DMETX))
IL: Independent Lab
LPC: Licensed Professional Counselor
LSA: Licensed Surgical Assistant
MT: Massage Therapist
MD: Doctor of Medicine
NP: Nurse Practitioner
OD: Doctor of Optometry
OT: Occupational Therapist
PA: Physician Assistant
PSY: Psychologist
PT: Physical Therapist
RAD: Radiology Facility

Note: Billing with any of the above License Type Codes does not guarantee reimbursement.

32. Name, address, city, state, and ZIP code of the location where the health care was rendered or services were provided (R)
33. Billing name of provider/supplier or billing service; address, city, state, ZIP code, and telephone #(R)

INSURANCE CARRIER INFORMATION:

INDICATE THE DATE THE CARRIER RECEIVED THE BILL.

Payment Information shall be provided using form DWC FORM-62, EOB, in accordance with Rule 133.304.