North Dakota Workforce Safety & Insurance

# ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE

MEDICAL SERVICES DIVISION
SFN 59582 (02/2021)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
**Telephone 800-777-5033**
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

## SECTION 1 – *Injured employee's information*

| Claim number | Injured employee's (First name) | (Last name) |
|---|---|---|
| Date of service | Provider | |

## SECTION 2 – *Provider responsibility*

As the provider it is your responsibility to:

- Complete this form for each individual date of service
- Indicate the recommended medical service and provide the estimated cost
- Review this form with the injured employee prior to providing the service and obtain their signature

| | **Service** | **Reason** | **Estimated cost** |
|---|---|---|---|
| ☐ | Massage Therapy | May not be a covered service | |
| ☐ | Acupuncture (Maximum of 18 treatments per claim) | May not be a covered service | |
| ☐ | Chiropractic Maintenance Care (Palliative care) | May not be a covered service | |
| ☐ | Nutritional Supplements | May not be a covered service | |
| ☐ | Trigger Point Injections (Maximum of 20 injections per claim) | May not be a covered service | |
| ☐ | Vertebral Axial Decompression Therapy | Not a covered service | |
| ☐ | Lower Level Laser Therapy | Not a covered service | |
| ☐ | Exercise Equipment | Not a covered service | |
| ☐ | Hot/Cold Packs or Biofreeze | Not a covered service | |
| ☐ | Dry Needling | Not a covered service | |
| ☐ | Other | May not be a covered service | |

## SECTION 3 – *Injured employee's responsibility*

As the injured employee it is your responsibility to:

- Review the selected service to make an informed decision about your medical care
- Ask the provider questions you may have regarding the recommended service
- Indicate your decision by choosing an option below and signing the form

Options: Check only one box

☐ **Option 1.** I want the selected service listed above.

- The provider may require payment at the time of service prior to billing WSI for the service
- If WSI does pay, the provider will refund payments I have made
- If WSI or my private insurance does not pay for the services, I am responsible for payment

☐ **Option 2.** I do not want the service recommended by the medical provider.

## SECTION 4 – *Signature*

Signing below means you have reviewed and understand this notice.

| **Injured employee's signature** | **Date** |
|---|---|
| | |