



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:			
<ul style="list-style-type: none"> • 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
<input type="checkbox"/>	Massage Therapy	May not be a covered service	
<input type="checkbox"/>	Acupuncture (Maximum of 18 treatments per claim)	May not be a covered service	
<input type="checkbox"/>	Chiropractic Maintenance Care (Palliative care)	May not be a covered service	
<input type="checkbox"/>	Nutritional Supplements	May not be a covered service	
<input type="checkbox"/>	Trigger Point Injections (Maximum of 20 injections per claim)	May not be a covered service	
<input type="checkbox"/>	Vertebral Axial Decompression Therapy	Not a covered service	
<input type="checkbox"/>	Lower Level Laser Therapy	Not a covered service	
<input type="checkbox"/>	Exercise Equipment	Not a covered service	
<input type="checkbox"/>	Hot/Cold Packs or Biofreeze	Not a covered service	
<input type="checkbox"/>	Dry Needling	Not a covered service	
<input type="checkbox"/>	Other	May not be a covered service	
SECTION 3 – Injured employee's responsibility			
As the injured employee it is your responsibility to:			
<ul style="list-style-type: none"> • 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			
<input type="checkbox"/> Option 1. I want the selected service listed above. <ul style="list-style-type: none"> • 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 			
<input type="checkbox"/> 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