North Dakota Workforce Safety & Insurance

BINDING DISPUTE RESOLUTION REQUEST

MEDICAL SERVICES DIVISION
SFN 19605 (08/2024)

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Bismarck ND 58506-5585
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Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 – *Claim information*

Claim number	Injured employee's (First name)	(Last name)
Date of birth	Date of injury	

SECTION 2 – *Treatment information*

Type of treatment in dispute (Be as specific as possible. Example, lumbar fusion L5-S1, right shoulder MRI, medication, etc.)

Date(s) of service in dispute

Treatment disputed is
☐ Proposed ☐ Already provided

SECTION 3 – *Provider's information*

Provider's full name

Facility name (if applicable)		Facility Federal Tax ID	
Address			
City	State	ZIP code	
Contact person		Telephone number	
Are you the treating provider? ☐ Yes ☐ No	If no, list name of treating provider	Treating provider's telephone number	
Treating provider's address (if different from above)	City	State	ZIP code

SECTION 4 – *To be completed by requesting party. (Respond to the questions listed below and provide narrative information.)*

Is the disputed treatment the result of a utilization review (UR) decision?
☐ Yes ☐ No

If yes, has an appeal of the UR decision been completed?
☐ Yes ☐ No

If yes, submit the following documentation:

- Statement summarizing attempts to resolve this dispute
- Relevant and pertinent medical information regarding the dispute not already provided to Workforce Safety & Insurance

If no, you must appeal the UR decision before requesting binding dispute resolution by completing the UR Review Request (UR-C) form.

SECTION 5 – *Signature*

This form was completed by
☐ Provider ☐ Injured employee ☐ Injured employee's attorney ☐ Employer

I have answered all questions to the best of my ability and submitted documentation to support the request.

Signature	**Date**