



North Dakota Workforce
Safety & Insurance

**PRIOR AUTHORIZATION
REVIEW REQUEST**
UTILIZATION REVIEW DIVISION
SFN 58385 (08/2024)

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701-328-3786
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SECTION 1 – Claim information			
Date	Claim number	Injured employee's (First name)	(Last name)
Date of birth		Date of injury	
SECTION 2 – Request type and service date			
Submit medical documentation to support the medical necessity of this request. Fax both pages of this request form.			
<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Appeal		Scheduled date of procedure (if known)	
SECTION 3 – Contact information			
Person to notify with decision	Facility name	Preferred method of notification <input type="checkbox"/> Telephone <input type="checkbox"/> Fax <input type="checkbox"/> Email	
Telephone number	Fax number	Email address	
SECTION 4 – Ordering provider information			
Supply both the individual ordering provider and facility group/billing National Provider Identifier (NPI) and facility Tax Identification Number (TIN). WSI relies on this information to correspond with the individual provider and facility about this request.			
Provider's full name (MD, NP, PA)	Provider's individual NPI	Date of most recent office visit	
Facility name	Facility physical address		
City	State	ZIP code	
Facility TIN	Facility group/billing NPI	Facility telephone number	
SECTION 5 – Servicing facility information			
Supply the servicing facility NPI and TIN. WSI relies on this information to correspond with the facility about this request.			
Facility name	Facility physical address		
City	State	ZIP code	
Facility TIN	Facility group/billing NPI	Facility telephone number	
SECTION 6 – Imaging			
<input type="checkbox"/> Bone scan <input type="checkbox"/> CT Myelogram <input type="checkbox"/> CT Scan <input type="checkbox"/> Discogram (Levels) <input type="checkbox"/> MRI <input type="checkbox"/> MRI arthrogram <input type="checkbox"/> PET Scan <input type="checkbox"/> Other			
Part of body for procedure			
SECTION 7 – Surgery			
<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient			
Type of surgery			

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Claim number	Injured employee (First name)	(Last name)
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SECTION 8 – Injection

Supply the following required information where requested: Body part, number of injections, level(s), and location

Type of injection	Level(s)	Location
<input type="checkbox"/> Botox injection Body part		
<input type="checkbox"/> Epidural steroid injection (ESI) translaminar/intralaminar		<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Caudal
<input type="checkbox"/> ESI transforaminal or selective nerve root block	Level(s)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Facet joint intra-articular block	Level(s)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Facet medial branch block	Level(s)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Intra-articular sacroiliac (SI) joint injection		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Radiofrequency medial branch neurotomy (ablation)	Level(s)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Regional sympathetic block upper extremity; stellate ganglion Number of injections		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Regional sympathetic block lower extremity; lumbar Number of injections		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Viscosupplementation injection (ex. Hyaluronic acid, Synvisc) Body part Number of injections		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Other		

SECTION 9 – Therapy

<input type="checkbox"/> Hyperbaric oxygen treatment <input type="checkbox"/> Inpatient rehabilitation <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Work hardening/conditioning <input type="checkbox"/> Vision therapy		
Part of body	Date of surgery (if applicable)	
Treatment (ex. exercise)	Number of modalities per visit	
Start date for this request	End date for this request	Number of visits for this request
Number of visits used	Date of most recent therapy visit	Therapist name

SECTION 10 – Additional information

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