North Dakota Workforce Safety & Insurance

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE

MEDICAL SERVICES DIVISION
SFN 59582 (08/2017)

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 worker's information*

Claim number	Injured worker's (First name)	(Last name)
Date of service	Provider	

SECTION 2 – *Provider responsibility*

As the provider it is your responsibility to:

- Select the recommended medical service and provide the estimated cost
- Review this form with the injured worker prior to providing the service and obtain their signature
- Submit completed form to Workforce Safety & Insurance (WSI) if the injured worker received the service

	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	
☐	Other	May not be a covered service	

SECTION 3 – *Injured worker's responsibility*

As the injured worker 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.

- If WSI or my private insurance does not pay for the service, I am responsible for payment
- Payment may be required at the time of service and WSI is to be billed for service
- If WSI does pay, the medical provider will refund payments I have made

☐ **Option 2.** I don't want the service recommended by the medical provider.

SECTION 4 – *Signature*

Signing below means you have reviewed and understand this notice.

Injured worker's signature	**Date**