



**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**  
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Fraud and Safety Hotline 800-243-3331  
www.workforcesafety.com

<b>SECTION 1 – Injured worker's information</b>			
Claim number	Injured worker's (First name)		(Last name)
Date of service	Provider		
<b>SECTION 2 – Provider responsibility</b>			
As the provider it is your responsibility to:			
<ul style="list-style-type: none"> <li>Select the recommended medical service and provide the estimated cost</li> <li>Review this form with the injured worker prior to providing the service and obtain their signature</li> <li>Submit completed form to Workforce Safety &amp; Insurance (WSI) if the injured worker received the service</li> </ul>			
	<b>Service</b>	<b>Reason</b>	<b>Estimated cost</b>
<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"/>	Other	May not be a covered service	
<b>SECTION 3 – Injured worker's responsibility</b>			
As the injured worker it is your responsibility to:			
<ul style="list-style-type: none"> <li>Review the selected service to make an informed decision about your medical care</li> <li>Ask the provider questions you may have regarding the recommended service</li> <li>Indicate your decision by choosing an option below and signing the form</li> </ul>			
Options: check only one box			
<input type="checkbox"/> <b>Option 1.</b> I want the selected service listed above. <ul style="list-style-type: none"> <li>If WSI or my private insurance does not pay for the service, I am responsible for payment</li> <li>Payment may be required at the time of service and WSI is to be billed for service</li> <li>If WSI does pay, the medical provider will refund payments I have made</li> </ul>			
<input type="checkbox"/> <b>Option 2.</b> I don't want the service recommended by the medical provider.			
<b>SECTION 4 – Signature</b>			
Signing below means you have reviewed and understand this notice.			
<b>Injured worker's signature</b>			<b>Date</b>