



**MEDICAL SERVICES DISPUTE
RESOLUTION REQUEST**
MEDICAL SERVICES DIVISION
SFN 19605 (05/2017)

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 (First name)	(Last name)	Social Security number*
Telephone number			
SECTION 2 – 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 3 – Treatment information			
Type of treatment in dispute (Be as specific as possible. Example, lumbar fusion L5-S1, right shoulder MRI, etc.)			
Date(s) of service in dispute			
Treatment disputed is <input type="checkbox"/> Proposed <input type="checkbox"/> Already provided			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, has an appeal of the UR decision been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, submit the following documentation: <ul style="list-style-type: none"> • 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 <input type="checkbox"/> Provider <input type="checkbox"/> Injured worker <input type="checkbox"/> Injured worker’s attorney <input type="checkbox"/> Employer <input type="checkbox"/> Other			
I have answered all questions to the best of my ability and submitted documentation to support the request.			
Signature			Date

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.