



**ADVANCE BENEFICIARY
NOTICE OF NON-COVERAGE**
MEDICAL SERVICES DIVISION
SFN 59582 (10/2018)

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Bismarck ND 58506-5585
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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:			
<ul style="list-style-type: none"> • Complete this form for each individual date of service • Indicate 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 			
	Service	Reason	Estimated cost
<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"/>	Dry Needling	Not a covered service	
<input type="checkbox"/>	Other	May not be a covered service	
SECTION 3 – Injured worker’s responsibility			
As the injured worker it is your responsibility to:			
<ul style="list-style-type: none"> • 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			
<input type="checkbox"/> Option 1. I want the selected service listed above. <ul style="list-style-type: none"> • 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 			
<input type="checkbox"/> 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