ELECTRO MEDICAL DEVICE CERTIFICATION REQUEST

MEDICAL SERVICES DIVISION
SFN 54391 (02/2020)

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 employee's information*

Claim number	Injured employee's (First name)	(Last name)	
Date of birth		Date of injury	
Address			
City	State	ZIP code	Telephone number

SECTION 2 – *Medical provider information*

Ordering medical provider		Last date of service	
Address			
City	State	ZIP code	Telephone number

SECTION 3 – *Therapist information*

Therapist's name		Facility	
Address			
City	State	ZIP code	Telephone number

SECTION 4 – *Type of unit (medical provider prescription required)*

☐ TENS Unit ☐ Muscle Stimulator ☐ Combination Unit (Example: All stim)

☐ Other

Medical provider prescription attached
☐ Yes ☐ No

SECTION 5 – *Shipping information (where to ship unit)*

Name		
Address		
City	State	ZIP code

SECTION 6 – *Comments*

SECTION 7 – *WSI Internal use only*

☐ Approved ☐ Denied

Signature

M5