



**INDEPENDENT EXERCISE
PROGRAM REQUEST**
UTILIZATION REVIEW DIVISION
SFN 53630 (03/2025)

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SECTION 1 – Claim information			
Date	Claim number	Injured employee's (First name)	(Last name)
Date of birth		Date of injury	
SECTION 2 – Service request details			
<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Appeal			
Service requested			
Part of body			
Start date		End date	
Additional information			
SECTION 3 – Supporting documentation			
<input type="checkbox"/> Supporting documentation attached			
SECTION 4 – Requesting facility			
Facility name			
Address			
City		State	ZIP code
Requester name	Requester telephone number		Fax number
Preferred method of notification of recommendation <input type="checkbox"/> Telephone call OR <input type="checkbox"/> Fax			
SECTION 5 – Servicing facility			
Facility name			
Facility mailing address			
City		State	ZIP code
Facility Federal Tax ID		Facility telephone number	

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