North Dakota Workforce Safety & Insurance

PRIOR AUTHORIZATION REVIEW REQUEST

UTILIZATION REVIEW DIVISION

SFN 58385 (08/2024)

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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 – *Request type and service date*

Submit medical documentation to support the medical necessity of this request. Fax both pages of this request form.

☐ Prior Authorization ☐ Appeal	Scheduled date of procedure (if known)

SECTION 3 – *Contact information*

Person to notify with decision	Facility name	Preferred method of notification ☐ Telephone ☐ Fax ☐ Email
Telephone number	Fax number	Email address

SECTION 4 – *Ordering provider information*

Supply both the individual ordering provider and facility group/billing National Provider Identifier (NPI) and facility Tax Identification Number (TIN). WSI relies on this information to correspond with the individual provider and facility about this request.

Provider's full name (MD, NP, PA)	Provider's individual NPI	Date of most recent office visit
Facility name	Facility physical address	
City	State	ZIP code
Facility TIN	Facility group/billing NPI	Facility telephone number

SECTION 5 – *Servicing facility information*

Supply the servicing facility NPI and TIN. WSI relies on this information to correspond with the facility about this request.

Facility name	Facility physical address	
City	State	ZIP code
Facility TIN	Facility group/billing NPI	Facility telephone number

SECTION 6 – *Imaging*

☐ Bone scan ☐ CT Myelogram ☐ CT Scan ☐ Discogram (Levels)
☐ MRI ☐ MRI arthrogram ☐ PET Scan ☐ Other

Part of body for procedure

SECTION 7 – *Surgery*

☐ Outpatient ☐ Inpatient

Type of surgery

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Claim number	Injured employee (First name)	(Last name)

SECTION 8 – *Injection*

Supply the following required information where requested: Body part, number of injections, level(s), and location

Type of injection	Level(s)	Location
☐ Botox injection Body part		
☐ Epidural steroid injection (ESI) translaminar/intralaminar		☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Caudal
☐ESI transforaminal or selective nerve root block	Level(s)	☐ Right ☐ Left ☐ Bilateral
☐ Facet joint intra-articular block	Level(s)	☐ Right ☐ Left ☐ Bilateral
☐ Facet medical branch block	Level(s)	☐ Right ☐ Left ☐ Bilateral
☐ Intra-articular sacroiliac (SI) joint injection		☐ Right ☐ Left ☐ Bilateral
☐ Radiofrequency medical branch neurotomy (ablation)	Level(s)	☐ Right ☐ Left ☐ Bilateral
☐ Regional sympathetic block upper extremity; stellate ganglion Number of injections		☐ Right ☐ Left ☐ Bilateral
☐ Regional sympathetic block lower extremity; lumbar Number of injections		☐ Right ☐ Left ☐ Bilateral
☐ Viscosupplementation injection (ex. Hyaluronic acid, Synvisc) Body part Number of injections		☐ Right ☐ Left ☐ Bilateral
☐ Other		

SECTION 9 – *Therapy*

☐Hyperbaric oxygen treatment ☐Inpatient rehabilitation ☐Occupational therapy ☐Physical therapy ☐Speech therapy
☐Work hardening/conditioning ☐Vision therapy

Part of body	Date of surgery (if applicable)
Treatment (ex. exercise)	Number of modalities per visit

Start date for this request	End date for this request	Number of visits for this request
Number of visits used	Date of most recent therapy visit	Therapist name

SECTION 10 – *Additional information*

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