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|  | **SERVE AND PROTECT REIMBURSEMENT REQUEST**  EMPLOYER SERVICES /  LOSS CONTROL DIVISION  SFN 62398 (05/2025) | | 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](http://www.workforcesafety.com) |
| **Reimbursement request for paid, full-time firefighters and/or law enforcement officers. An employer may only submit one form per month.** | | | |
| **SECTION 1 –** *Employer information* | | | |
| Employer’s account number | | Employer’s name | |
| **SECTION 2 –** *Contact information* | | | |
| Contact name | Telephone number | | Email address |
| **SECTION 3 –** *Reimbursement supporting documentation* | | | |
| Submit the following supporting documentation  Serve and Protect Reimbursement excel file  Copy of the paid invoice and proof of payment for medical exam | | | |

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| **SECTION 4 –** *Reimbursement method (choose either credit card or check and indicate the contact information to submit payment)* | | | |
| **Total reimbursement request** | | | |
| Credit card | | | |
| Contact name | Telephone number | | Email address |
| Check | | | |
| Supplier ID | | | |
| Contact name | Telephone number | | Email address |
| Mailing address | | | |
| City | State | | ZIP code |
| **SECTION 5 –** *Signature* | | | |
| By signing this form, I agree that the information contained here is accurate and true. I further understand that submission of false, misleading or fraudulent information may subject this employer to civil, criminal and administrative penalties. | | | |
| Submitted by (Printed name) | | Title | |
| Submitted by (Signature) | | Date | |
| **SECTION 6 –** *For WSI use only* | | | |
| Supplier ID | | Amount of reimbursement | |
| WSI signature/approval | | Date | |
| WSI review signature/approval | | Date | |
| Notes | | | |

**Reimbursement Guidelines**

Requests for reimbursement are for employers who employ paid, full-time firefighters or law enforcement officers. Requests must be received within 1 year from the date of medical exam.

**Medical Exam Reimbursement**

* Reimbursement is based on continuous years of service as a paid, full-time firefighter or law enforcement officer regardless of where the service occurred. (see NDCC § 65-01-15.1.3.a).
* The medical exam schedule is:
  + Upon hire
  + 1 to 10 years of service, medical exam every 5 years
  + 11 to 20 years of service, medical exam every 3 years
  + 21 or more years of service, medical exam every year
* The maximum reimbursement amount is up to $250 per employee.
* WSI will accept one of the following as supporting documentation.
  + Copy of the paid invoice and proof of payment for medical exam (ex. cleared check, billing statement, or credit card receipt). The invoice must include the provider’s name, location, and telephone number; employee’s name; date of medical exam; and dollar amount.
  + Copy of the EOB and proof of payment if employer reimbursed the employee for the cost of the medical exam.

Questions relating to the program or reimbursement, contact the program specialist a at 800-777-5033 or email at wsiserveprotect@nd.gov.