



**MEDICAL BILL APPEAL**  
 MEDICAL SERVICES DIVISION  
 SFN 58310 (10/2019)

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)
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**SECTION 2 – Provider’s information**

Provider/facility name		
Contact name	Telephone number	Fax number

**SECTION 3 – Appeal information**

WSI bill number(s)	<input type="checkbox"/> CMS 1500	<input type="checkbox"/> UB-04
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**Reason for appeal** (select all that apply)

Medical records not received (RC 212)  
 Attach medical records with this form

Service not pre-certified (RC 80) & (RC 91)  
 Provide description of appeal in Section 4

Reconsideration of payment  
 Provide description of appeal in Section 4

Dates of service		Unit(s)	Place of service	CPT/HCPCS/ADA/Rev code	Modifier	Tooth number/surface	Amount billed	Amount paid
From	To							

**SECTION 4 – Explanation of appeal**

Please attach supporting documentation.

**M6**