NORTH CAROLINA INDUSTRIAL COMMISSION

MEDICAL PROVIDER DISPUTE RESOLUTION QUESTIONNAIRE

(N.C. GEN. STAT. §97-26(i))

Medical Provider MUST Complete Sections A-C Below

A. MEDICAL PROVIDER INFORMATION

Medical Provider

Contact Name

Date(s) of Service

Address City State Zip

Total Charges for Services Provided

( ) - ( ) -

Telephone Fax

Email

The above named medical provider is seeking payment for the attached medical services provided in a workers' compensation claim. The medical provider has received information that the employer is
□ Insured by the carrier listed below □ Self-insured □ Uninsured

B. EMPLOYEE/CLAIMANT

Employee's Name IC File No

Address

City State Zip

( ) - ( ) -

Home Telephone Work Telephone

XXX-XX □ M □ F / /

Last 4 Digits of SSN Sex Date of Birth

C. EMPLOYER/CARRIER INFORMATION

( ) -

Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Adjustor

Carrier's Address City State Zip

( ) -

Carrier's Telephone Number Carrier's Email Address

Employer/Carrier MUST Complete Section D Below

D. EMPLOYER/CARRIER RESPONSE

The above named employer and/or workers' compensation insurance carrier must provide the information requested below regarding this case and the attached medical expenses to the above named medical provider within 20 days of receiving this questionnaire.

The above named employer and/or workers' compensation insurance carrier:
□ is not the employer or carrier for this claim.
□ denies liability for this workers' compensation claim. Date of Denial: _____
□ admits liability for this workers' compensation claim.

If liability admitted, do you accept liability for the attached medical expenses? □ Yes □ No
If liability denied for this claim or the attached medical expenses, please explain: _____

_____

Has either party to this claim requested a hearing before the Industrial Commission? □Yes □ No
Has a compromise settlement agreement been approved? □ Yes □ No Date Approved: _____

_____ _____

Signature of (Check One) □ Employer, □ Attorney, □ Carrier Representative Date

_____

Print Name

FORM 26I