

**INTERVENOR'S REQUEST THAT CLAIM BE ASSIGNED FOR HEARING  
(N.C. GEN. STAT. § 97-26(i))**

**A. INTERVENOR/MEDICAL PROVIDER INFORMATION**

Medical Provider \_\_\_\_\_  
Date(s) of Service \_\_\_\_\_  
Total Charges for Services Provided \_\_\_\_\_

Contact Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
( ) - ( ) -  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_

**B. EMPLOYEE/CLAIMANT**

Employee's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
( ) - ( ) -  
Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_  
- -  M  F / /  
Social Security Number \_\_\_\_\_ 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 Fax Number \_\_\_\_\_

The above-named Intervenor, \_\_\_\_\_ files notice that, pursuant to N.C. Gen. Stat. § 97-26(i) and Rule 24 of the North Carolina Rules of Civil Procedure, N.C. Gen. Stat. § 1A-1, it has been allowed a limited intervention in this matter by Order dated \_\_\_\_\_. The Intervenor and the parties above have failed to resolve a dispute regarding payment of charges for medical services indicated above and request a hearing.

Name of Individual Receiving Services: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Has Claim been:  
 Admitted.  Denied. Date of Denial: \_\_\_\_\_

Has a compromise settlement agreement been approved?  Yes  No Date Approved: \_\_\_\_\_

Has any party to this claim previously requested a hearing before the Industrial Commission?  Yes  No

**CERTIFICATION**

I, \_\_\_\_\_, hereby certify that this case is ready for hearing  
Print Name  
and request a hearing in  Wake County or  \_\_\_\_\_ County.

Signature of (Check One)  Attorney,  Medical Provider/Intervenor \_\_\_\_\_ Date \_\_\_\_\_

**Note:** A copy of this form must be sent to opposing parties. The original of this form must be sent to the Industrial Commission at the address below.