North Carolina
Industrial Commission

MINUTES

MEDICAL PROCEDURES CHANGES

20 April 1992

1. The N. C. Industrial Commission is soliciting written comments concerning the establishment of a Per Diem Rate Schedule method for reimbursement of inpatient hospital charges pursuant to North Carolina General Statute 97, to become effective coincidentally with the revised Medical Fee Schedule on 1 January 1993. Comments mailed to the below address by 14 April 1992 will be considered:

B.J. Moore
Chief Medical Fee Examiner
N.C. Industrial Commission
430 N. Salisbury St.
Raleigh, NC 27611

2. The N. C. Industrial Commission is the ONLY body authorized to reduce medical bills associated with workers' compensation claims in North Carolina.

Effective 1 July 1992 the Commission will change the dollar parameter of Minor Medical (Medical Only) claims from $1,000.00 to $2,000.00.
In order to accommodate the demand for review and/or reduction of minor medical bills, the Commission has developed an electronic method for overnight processing of these medical bills which negates the need to establish an I. C. File. While Key Risk Management Services piloted this program with the Commission and is currently the only company routinely processing claims in this manner, Fortis Corporation and Intercorp will likely soon qualify to provide these services also. Other companies interested in qualifying for this program should contact Phillip R. Wilson, Administrator, N. C. Industrial Commission. Due to the increased interest in this program and the other electronic transmission efforts of the Commission, a strict "first-come, first-serve" policy has been established for system qualification.

3. Preferred Provider Organizations are acceptable to the Commission. A carrier, self-insured, or claims processor should submit medical bills for review/approval/reduction by the Commission and take the negotiated discounts upon receipt of the Medical Bill Analysis from the Commission. The Form 28B submitted in each case must reflect the actual payments to the Medical Care Providers.

James J. Booker
Chairman

J. Harold Davis
Commissioner

J. Randolph Ward
Commissioner

FORM 18M
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____
Employer_____
Address_____
Telephone_____
Carrier_____
Address_____
Telephone_____

EMPLOYEE'S CLAIM FOR ADDITIONAL MEDICAL COMPENSATION PURSUANT TO N. C. GEN. STAT. § 97-25.1 (APPLICABLE TO INJURIES BY ACCIDENT ON OR AFTER JULY 5, 1994)

SECTION A. TO EMPLOYER OR CARRIER/ADMINISTRATOR AND THE INDUSTRIAL COMMISSION:

1. I, _____, employee, claim additional medical compensation as a result of an injury by accident or an occupational disease which occurred on or by _____, 199__, because _____.
2. The doctor's statement below ☐ has / ☐ has not been signed by my treating physician *(optional)*.
3. I ☐ am/☐ am not attaching additional medical and/or other supporting documentation *(optional)*.

(Place your I.C. File No. on each attachment.)

_____
SIGNATURE OF EMPLOYEE DATE

Name and address of employee's attorney, if any: _____
_____

EMPLOYEE: THE ORIGINAL AND A COPY OF THIS FORM SHALL BE SENT TO THE INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611, AND A COPY SENT TO THE EMPLOYER OR CARRIER/ADMINISTRATOR.

SECTION B. TREATING PHYSICIAN'S STATEMENT:

This is to certify that:

1. I am the above employee's treating physician. My area of medical practice is_____, and my treatment began on _____, 199_____.
2. In my opinion, there is a substantial risk that the employee will need the following additional medical care or monitoring (including medical, surgical, hospital, nursing, rehabilitation services, medicines, sick travel, replacement of artificial members, medical and surgical supplies, and other treatment): _____. The need for this medical treatment results from the injury by accident or occupational disease as set forth in Section A. above.

_____
SIGNATURE OF TREATING PHYSCIAN PRINTED NAME DATE

_____
ADDRESS CITY STATE ZIP

FORM 21 rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone _____
Employer_____
Address_____
Telephone_____
Carrier_____
Address_____
Telephone_____

AGREEMENT FOR COMPENSATION FOR DISABILITY PURSUANT TO N.C. GEN. STAT. § 97-82

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act, and _____ _____ is the carrier/administrator for the employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by _____, 199___.
3. The injury by accident or occupational disease resulted in the following injuries:_____ _____.
4. The employee ☐ was ☐ was not paid for the entire day when the injury occurred.
5. The average weekly wage of the employee at the time of the injury, **including overtime and all allowances**, was $ _____, subject to verification unless otherwise agreed upon in line 9 below.
6. Disability resulting from the injury or occupational disease began on _____, 199_____.
7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $ _____ per week beginning _____. 199___, and continuing for _____ weeks.
8. The employee ☐ has / ☐ has not returned to work for _____ on_____, 199____, at an average weekly wage of $ _____.
9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____ _____ _____
10. If applicable, the Second Injury Fund Assessment is $_____. Check ☐ is ☐ is not attached.
11. The date of this agreement is _____, 199_____.

_____
NAME OF EMPLOYER | SIGNATURE | TITLE

_____
NAME OF CARRIER/ADMINISTRATOR | SIGNATURE | TITLE

EMPLOYEE MUST FILL IN DATE, AMOUNT OF PAYMENT AND SIGN

FIRST PAYMENT RECEIVED:_____.199___ AMOUNT RECEIVED $ _____

_____
SIGNATURE OF EMPLOYEE | ADDRESS

_____
SIGNATURE OF EMPLOYEE'S ATTORNEY | ADDRESS

☐ Check box if no attorney retained.

☐ Check box if employee is in managed care.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
CLAIMS EXAMINER

_____
DATE

SEE REVERSE FOR INSTRUCTIONS

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two (2) years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Failure to file Form 28B rev., Report Of Compensation And Medical Compensation Paid, within sixteen (16) days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, within twenty (20) days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show good cause for not submitting the agreement.

NEED ASSISTANCE ?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (919) 733-0345

FORM 24 rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____
Employer_____
Address_____
Telephone_____
Carrier_____
Address_____
Telephone_____

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION PURSUANT TO N.C. GEN. STAT. § 97-18.1

IMPORTANT NOTICE TO EMPLOYEE: YOUR BENEFITS MAY STOP UNLESS YOU OBJECT RIGHT AWAY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION. IF THE INDUSTRIAL COMMISSION HAS NOT RECEIVED THE COMPLETED COPY OF THIS FORM FROM YOU BY _____ _____, 199_____, YOUR BENEFITS MAY BE STOPPED WITHOUT FURTHER NOTICE TO YOU. IF YOU OBJECT, YOU MAY HAVE THE RIGHT TO AN INFORMAL HEARING BY THE INDUSTRIAL COMMISSION BEFORE YOUR BENEFITS CAN BE STOPPED. (THE DATE TO BE INSERTED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR ABOVE SHALL BE SEVENTEEN (17) DAYS AFTER THIS APPLICATION WAS MAILED TO THE INDUSTRIAL COMMISSION.)

SECTION A. **TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR:**

1. Date of injury by accident :_____, 199____
   Date disability began: _____, 199____

2. Nature and extent of injury: _____
   _____.

3. Number of weeks compensation paid: _____
   From: _____, 199____ To: _____, 199____

4. Total amount of indemnity compensation paid to date: $ _____

5. Check applicable box(s):
   - ☐ a. An agreement was approved by the Industrial Commission on _____, 199____.
   - ☐ b. The employer admitted employee's right to compensation pursuant to N.C. Gen. Stat. § 97-18(b). (This provision becomes effective January 1, 1995)
   - ☐ c. The employer paid compensation to employee without contesting claim within the statutory period provided under N.C. Gen. Stat. § 97-18(d). (This provision becomes effective January 1, 1995)
   - ☐ d. Other:_____
     _____

SEE REVERSE OF FORM

6. Application is made to ☐ terminate or ☐ suspend compensation to the employee on the ground that

_____

_____

_____

_____

7. ☐ Check box if employee is in managed care.

In addition to filing the original of this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was mailed to the employee at _____(address) and employee's attorney of record, if any, on _____, 199____. The attached documents consist of _____ (number) pages.

_____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR PRINTED NAME TELEPHONE NUMBER DATE

SECTION B. <u>IF YOU THINK YOUR COMPENSATION SHOULD NOT STOPPED, YOU SHOULD COMPLETE THIS SECTION</u>.

1. I do not think my compensation should be stopped because:_____

_____

_____

_____

2. Enclose and specifiy the number of pages of documents the Industrial Commission should consider: _____(number).

3. Give a telephone number at which you can be reached from Monday through Friday between 8:00 a.m. and 5:00 p.m.: _____. You will be notified by the Industrial Commission as to when the informal hearing will be held.

4. You may contact the Industrial Commission at (919) 733-0345 if you need assistance in completing this form, need additional time to submit medical records, or to obtain documents you have not been able to obtain.

_____

SIGNATURE OF EMPLOYEE WITNESS DATE

EMPLOYEE: SEND A COPY OF THIS FORM AND SUPPORTING DOCUMENTS TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU ARE RECEIVING COMPENSATION. SEND THE ORIGINAL TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH NC 27611.

FORM 25R rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

EVALUATION FOR PERMANENT IMPAIRMENT

EMPLOYEE'S WORK-RELATED INJURY WILL RESULT IN:

MEMBER	% OF IMPAIRMENT (IF AMPUTATION, DESCRIBE ON REVERSE.)
1) Thumb	
2) Index Finger	
3) Middle Finger	
4) Ring Finger	
5) Little Finger	
6) Great Toe	
7) Toes (other than great toe)	
8) Hand	
9) Arm	
10) Foot	
11) Leg	
12) Back	

_____
Physician Signature

_____
Printed Name

_____
Date

_____
Address

_____
Federal Tax Number

TEETH

Age of employee _____
List all crowns by number_____
List all extractions by number_____
Has dental work been completed? ☐ Yes / ☐ No

VISION

List vision reading without the use of a corrective lens.
Distance _____
Near_____

HEARING

Scale used _____ Percentage of loss: Right ear_____
PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS Left ear _____

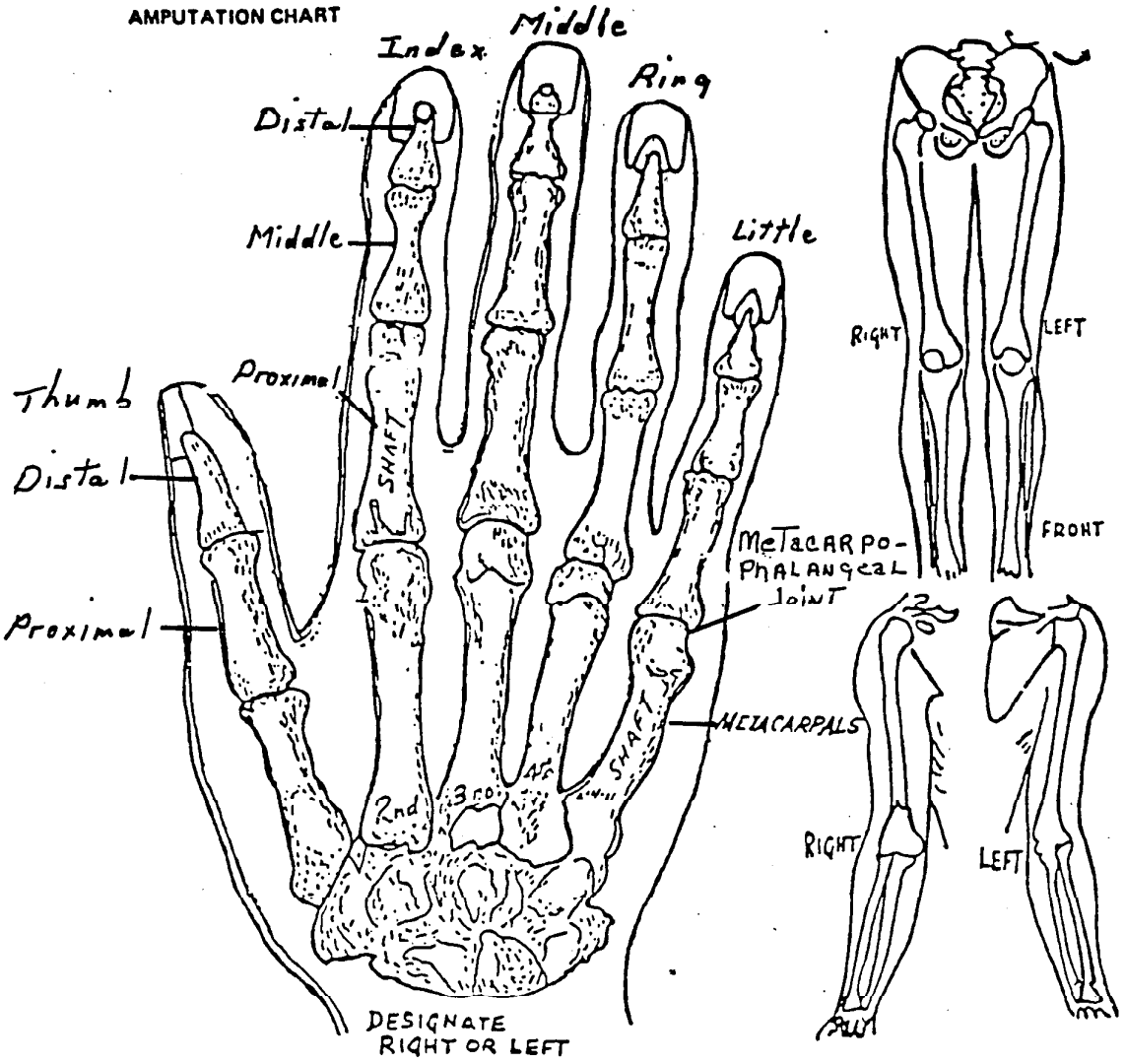
OTHER

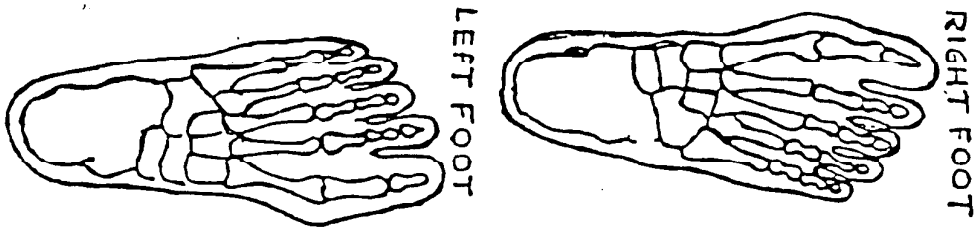
Permanent injury to or impairment of any other organ or part of body (identify) :_____
Disfigurement: ☐ Yes / ☐ No Location: ☐ face / ☐ head / ☐ body

EMPLOYER : THE ORGINAL OF THIS FORM SHALL BE SENT TO: INDUSTRIAL COMMISSION , 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611, AND A COPY OF THIS FORM MUST BE PROVIDED TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY.

FORM 25R rev.
3/15/95
PAGE 2

AMPUTATION CHART





Comments: _____

_____

_____

_____

_____

_____

_____

Rule 405

Computation of Compensation for Amputations

(1) Amputation of any portion of the bone of a distal phalange of a finger or toe at or distal to the visible base of the nail will be considered as equivalent to the loss of one-fourth (1/4) of such finger or toe.

(2) Amputation of any portion of the bone of the distal phalange of a finger or toe proximal to the visible base of the nail will be considered as equivalent to the loss of one-half (1/2) of such finger of toe.

(3) Amputation through the forearm at a point so distal to the elbow as to permit satisfactory use of a prosthetic appliance with retention of full natural elbow function shall be considered amputation of the hand. Otherwise, it shall be considered amputation of the arm.

(4) Amputation through the lower leg at a point so distal to the knee as to permit satisfactory use of a prosthetic appliance with retention of full natural knee function shall be considered amputation of the foot. Otherwise, it shall be considered amputation of the leg.

FORM 26 rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION PURSUANT TO N.C. GEN. STAT. § 97-82

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. The employee ☐ returned to work / ☐ was rated on _____, 199___, at a weekly wage of $ _____.
   (If the employee has not returned to work or if the employee has returned to work at reduced wages, a Form 28B must accompany this agreement.)
2. The employee became totally disabled on _____, 199___.
3. The average weekly wage of the employee ☐ was reduced / ☐ was increased on _____, 199___, from $ _____ per week to $_____ per week.
4. The employee was rated as having _____ percent permanent partial impairment of the following member of the body _____.
5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week beginning _____,199___, and continuing for _____weeks. The type of compensation disability is _____.
6. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability:
   _____
   _____
7. If applicable, the Second Injury Fund Assessment is $_____. Check ☐ is ☐ is not attached.
8. The date of this agreement is _____, 199_____.

_____
SIGNATURE OF EMPLOYEE — ADDRESS

_____
SIGNATURE OF EMPLOYEE'S ATTORNEY — ADDRESS

_____
NAME OF EMPLOYER — SIGNATURE — TITLE

_____
NAME OF CARRIER/ADMINISTRATOR — SIGNATURE — TITLE

☐ Check box if no attorney retained.

☐ Check box if employee is in managed care.

SEE REVERSE FOR INSTRUCTIONS

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
CLAIMS EXAMINER

_____
DATE

IMPORTANT NOTICE TO EMPLOYEE CLAIMING
ADDITIONAL WEEKLY CHECKS
OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two (2) years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE
INJURED BEFORE JULY 5, 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE
INJURED ON OR AFTER JULY 5, 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

IMPORTANT NOTICE TO EMPLOYER

This form is to be used only to supplement Form 21 rev., Agreement for Compensation for Disability Pursuant to N.C. Gen. Stat. § 97-82, or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Failure to file Form 28B rev., Report Of Compensation And Medical Compensation Paid, within sixteen (16) days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, within twenty (20) days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show good cause for not submitting the agreement.

NEED ASSISTANCE ?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (919) 733-0345

FORM 28 rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

RETURN TO WORK REPORT

EMPLOYER: THE USE OF THIS FORM IS NOT APPLICABLE WHEN AN EMPLOYEE HAS RETURNED TO WORK ON A TRIAL RETURN TO WORK BASIS PURSUANT TO N.C. GEN. STAT. § 97-32.1, IN WHICH CASE FORM 28T MUST BE USED.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING INFORMATION WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING:

1. Date of injury:_____
2. Date disability began:_____
3. Date returned to work:_____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES:

Employee is being paid at the rate of $ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer:_____
2. Address:_____
3. Telephone:_____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR | TITLE | DATE

EMPLOYER: THE ORIGINAL OF THIS FORM SHALL BE SENT TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611, AND A COPY SENT TO THE EMPLOYEE AND THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY. FORM 28B rev. MUST BE FILED TO REPORT THE AMOUNT AND LAST DATE COMPENSATION AND/OR MEDICAL COMPENSATION WERE PAID.

FORM 28B rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID AND NOTICE OF RIGHT TO ADDITIONAL MEDICAL COMPENSATION

1. Date of accident or disability from occupational disease _____, 19____.
2. Salary ☐ was / ☐ was not continued.
3. Number of weeks temporary total _____from _____199____, through _____199____.
4. Number of weeks temporary partial _____from _____199____, through _____199____.
5. Number of weeks permanent partial _____from _____199____, through _____199____.
6. Disfigurement amount paid $_____
7. Death benefits paid $_____
8. Loss of organ or body part benefits paid $_____
9. Total of lines 3 through 8, including any attorney fee paid to employee's attorney $_____
10. Compromise settlement agreement amount $_____
11. a. Total medical paid $_____ Does this include final medical? ☐ Yes / ☐ No
    (Include bills for nursing, doctor, hospital, drugs, etc., but exclude rehabilitation and "medical only" paid)
    b. Total rehabilitation paid $ _____
    c. Total "medical only" paid $ _____
12. Total of lines 9, 10, 11.a., and 11.b. $_____
13. Miscellaneous payments:

    Funeral benefits $_____
    Second injury fund $_____
    Hearing costs $_____
    Expert witness fees $_____
    Other $_____

    Total Miscellaneous Payments

    $_____

14. Employee has returned to work? ☐ Yes / ☐ No
    If so, at what wage?_____on what date?_____, 199__
15. Date last compensation check forwarded _____ Date last medical compensation paid_____
16. Does this report close the case (including payment of final compensation)? ☐ Yes / ☐ No

_____
NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

_____
SIGNATURE TITLE DATE

THIS FORM MUST BE FILED WITH THE INDUSTRIAL COMMISSION AND A COPY PROVIDED THE EMPLOYEE WITH HIS LAST COMPENSATION CHECK WITHIN SIXTEEN (16) DAYS FOLLOWING FINAL PAYMENT OF COMPENSATION.

****SEE REVERSE SIDE FOR IMPORTANT NOTICE****

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

If the answer to item no. 16 is "Yes," this is to notify you that upon receipt of this form your compensation stops. If you claim further compensation, you must notify the Industrial Commission in writing within two (2) years from the date of receipt of your last compensation check or your rights to these benefits may be lost .

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL MEDICAL BENEFITS INJURED BEFORE JULY 5, 1994

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL MEDICAL BENEFITS INJURED ON OR AFTER JULY 5, 1994

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

DEFINITION OF MEDICAL COMPENSATION

The term "medical compensation" means medical, surgical, hospital, nursing and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, as may reasonably be required to effect a cure or give relief, and for such additional time, as in the judgment of the Industrial Commission, will tend to lessen the period of disability; and any original artificial members as may reasonably be necessary at the end of the healing period, and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. N.C. Gen. Stat. § 97-2(19).

NEED ASSISTANCE

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (919) 733-0345

FORM 28T
2/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee _____
Social Security No._____
Address _____
Telephone _____

Employer _____
Address_____
Telephone _____

Carrier _____
Address_____
Telephone _____

NOTICE OF TERMINATION OF COMPENSATION BY REASON OF TRIAL RETURN TO WORK PURSUANT TO N.C. GEN. STAT. § 97-18.1(b) AND N.C. GEN. STAT. § 97-32.1

IMPORTANT NOTICE TO EMPLOYEE: YOUR DISABILITY COMPENSATION HAS BEEN TERMINATED SINCE YOU HAVE RETURNED TO WORK. YOU ARE ENTITLED TO A TRIAL RETURN TO WORK FOR A PERIOD NOT TO EXCEED NINE (9) MONTHS, UNLESS YOU HAVE BEEN RELEASED BY THE AUTHORIZED TREATING PHYSICIAN TO UNRESTRICTED WORK, IN WHICH CASE YOUR TRIAL RETURN TO WORK MAY BE LIMITED TO FORTY-FIVE (45) DAYS. DURING YOUR TRIAL RETURN TO WORK YOU MAY BE ENTITLED TO PARTIAL DISABILITY COMPENSATION IF, BECAUSE OF YOUR ON-THE-JOB INJURY, YOU EARN LESS WAGES NOW THAN BEFORE YOUR INJURY. IN ORDER TO REQUEST THAT YOUR COMPENSATION BE REINSTATED IF YOUR TRIAL RETURN TO WORK IS UNSUCCESSFUL, YOU SHOULD COMPLETE FORM 28U. ALSO YOU SHOULD NOTIFY THE PERSON NAMED BELOW IN ORDER TO REQUEST THAT YOUR COMPENSATION BE REINSTATED:

_____
NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR ADDRESS TELEPHONE NUMBER

WHEN AN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS, FORM 28 rev. MUST BE USED.

EMPLOYER: COMPLETE THE FOLLOWING.

1. Date of injury:_____,199___
2. Date disability began:_____,199___
3. Date temporary total compensation was/will be terminated:_____199____, when the employee returned/will return to work:
   at the ☐ same or greater wages, than received at the time of injury, or
   at ☐ reduced wages which were/are paid at the rate of $_____weekly.
   If employee has returned to work at reduced wages, is employee entitled to compensation for partial disability pursuant to N.C. Gen. Stat. § 97-30? ☐ yes ☐ no
   If not, explain:_____
   _____
   _____
4. If different employer: Name:_____
   Address:_____
   Telephone:_____

_____
SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR TITLE DATE

EMPLOYER: THE ORIGINAL OF THIS FORM SHALL BE SENT TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611, AND A COPY SENT TO THE EMPLOYEE AND THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY. FORM 28B rev. MUST BE FILED TO REPORT THE AMOUNT AND LAST DATE COMPENSATION AND/OR MEDICAL COMPENSATION WERE PAID.

FORM 28U
2/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO._____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____
Employer_____
Address_____
Telephone_____
Carrier_____
Address_____
Telephone_____

EMPLOYEE'S REQUEST THAT COMPENSATION BE REINSTATED AFTER UNSUCCESSFUL TRIAL RETURN TO WORK PURSUANT TO N.C. GEN. STAT. § 97-32.1

SECTION A. EMPLOYEE: COMPLETE AND SEND TO EMPLOYER AND CARRIER/ADMINISTRATOR.

1. I request that my total disability compensation be resumed immediately. I had a trial return to work for _____ (name of employer) from _____, 199___ (date first worked) until _____, 199___ (date last worked). The date of my injury by accident or the date of disability from my occupational disease was _____, 199___.
2. Explain in detail the reasons you are no longer working: _____
3. The following MUST be obtained by the employee from the authorized treating physician:

AUTHORIZED TREATING PHYSICIAN'S STATEMENT

This is to certify the employee is prevented from continuing the trial return to work due to the employee's injury for which compensation has been paid. My medical specialty is:_____

SIGNATURE OF AUTHORIZED TREATING PHYSICIAN | PRINTED NAME | DATE

ADDRESS | CITY | STATE | ZIP

4. If your return to work was not with the employer from whom you have received workers' compensation, you MUST complete the following Release:

EMPLOYEE'S RELEASE & REQUEST FOR EMPLOYMENT INFORMATION

I hereby request and authorize my last employer, _____ (name and address of last employer), to release information as listed below in Section B. relating to my trial return to work to my prior employer and carrier/administrator listed above, or their attorney of record.

READ BEFORE SIGNING

SIGNATURE OF EMPLOYEE | DATE

SEND A COPY OF THIS FORM TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU WERE RECEIVING WORKERS' COMPENSATION. SEND THE ORIGINAL TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611. IF YOU NEED ASSISTANCE, YOU MAY TELEPHONE THE INDUSTRIAL COMMISSION AT (919) 733-0345.

SECTION B. LAST EMPLOYER: COMPLETE AND RETURN TO SENDER.

First Date Worked:_____ Last Date Worked:_____ Total Wages Earned $_____

Explain in detail the reasons this employee is no longer working for you:_____

SIGNATURE OF LAST EMPLOYER | TITLE | DATE

FORM 36 rev.
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. No. _____

SUBPOENA FOR WITNESS

Before the North Carolina Industrial Commission
430 North Salisbury Street
Dobbs Building
Raleigh, North Carolina 27611

THE STATE OF NORTH CAROLINA

To the Sheriff of _____ County - Greetings:

You are hereby commanded to summon _____

to be and appear before the North Carolina Industrial Commission at the following location: _____

_____ County, _____ City, _____

_____ Street Address, on _____, 199____, at _____ o'clock to give evidence in a case

then and there to be tried, wherein _____,

Plaintiff,

and _____ Defendant(s) are parties.

Physicians who are called to offer expert medical testimony are not required to appear at the above-designated time; but instead, physicains are to stand-by from the time the case is scheduled and for the remainder of the business day. The physician will be telephoned at least 30 minutes before testifying.

Failure to comply with this subpoena may result in sanctions as provided by law.

Issued this _____ day of _____, 199___.

This subpoena is served at the request of: _____

_____

(List name of party and name of attorney, or if no attorney, so indicate)

Date Received_____

Date Served_____

_____
Sheriff

_____
Chairman
Industrial Commission

***SEE REVERSE FOR SUBPOENA TO PRODUCE ITEMS OR DOCUMENTS ***

SUBPOENA TO PRODUCE ITEMS OR DOCUMENTS

Pursuant to the required appearance, you are hereby commanded to bring with you the following items or documents:

_____

_____

_____

_____

_____

(Describe with particularity)

Chairman
Industrial Commission

FORM 51
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

ANNUAL CONSOLIDATED FISCAL REPORT OF "MEDICAL ONLY" OR "LOST TIME" CASES

It is the responsibility of the Carrier, Self-Insured Employer, Group Self-Insured as certified by the North Carolina Department of Insurance, and Statutory Self-Insured (State Agencies and Political Subdivisions) to submit a consolidated fiscal report yearly to the North Carolina Industrial Commission. Third Party Administrators may file on behalf of the parties required to make this filing. The information requested below must be submitted on or before July 30 of each year. This Form 51 shall cover the preceding twelve calendar months beginning each July 1, and ending June 30.

	Name of Carrier, Self-Insured Employer, Group Self-Insured as certified by the North Carolina Department of Insurance, or Statutory Self-Insured (State Agencies and Political Subdivisions)

All Must Complete The Following:

1. Total Number Of "Medical Only" Cases: _____
2. Total Amount Paid "Medical Only" Cases: _____

Complete The Following Section Only If You Are A Managed Care Insurer Or Are Directly Applying The Industrial Commission Medical Fee Schedule To Submitted Medical Bills:

3. Total Number Of "Lost Time" Cases: _____
4. Total Amount Paid Excluding Rehabilitation: $_____
5. Total Amount Paid For Rehabilitation: $_____
6. Total Amount Paid (Add lines 4 and 5): $_____

Address Of Submitting Office:

_____

_____

_____

_____

REPORTING YEAR: JULY 1, 199____ THROUGH JUNE 30, 199____

FORM 60
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO._____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO COMPENSATION PURSUANT TO N.C. GEN. STAT. § 97-18(b)

TO EMPLOYEE: Your employer **admits** your right to compensation for an ☐ injury by accident on _____,199___ / ☐ occupational disease as of _____,199___.

THE FOLLOWING IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND DOES NOT CONSTITUTE AN AGREEMENT:

1. The description of the injury by accident or occupational disease is:
   _____
   _____
2. The employee was paid for the entire day of injury. ☐ **Yes** ☐ **No**
3. The employee's average weekly wage, including overtime and all allowances, was $_____, which results in a weekly compensation rate of $_____.
   - ☐ **a.** Temporary total compensation is being paid at the compensation rate above.
   - ☐ **b.** Temporary partial compensation is being paid in the amount of $_____.
   - ☐ **c.** Other:_____.
4. The disability resulting from the injury began on _____, 199___, and compensation commenced on _____, 199___.

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

EMPLOYER: FAILURE TO FILE FORM 28B rev., REPORT OF COMPENSATION AND MEDICAL COMPENSATION PAID, WITHIN SIXTEEN (16) DAYS AFTER LAST PAYMENT PURSUANT TO AN AGREEMENT OR AWARD SUBJECTS EMPLOYER OR CARRIER/ADMINISTRATOR TO A PENALTY PURSUANT TO N.C. GEN. STAT. § 97-18(h). FORM 30 MUST BE USED FOR COMPENSABLE INJURIES RESULTING IN DEATH. A COPY OF THIS FORM SHALL BE PROVIDED TO THE EMPLOYEE AND THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY, AND THE ORIGINAL PROVIDED TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, , RALEIGH, NC 27611.

FORM 61
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO._____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____
Employer_____
Address_____
Telephone_____
Carrier_____
Address_____
Telephone_____

DENIAL OF WORKERS' COMPENSATION CLAIM PURSUANT TO N.C. GEN. STAT. § 97-18(c) & N.C. GEN. STAT. § 97-18(d)

TO EMPLOYEE,OR IN CASES OF DEATH, DEPENDENT(S) OR NEXT OF KIN:

This is to inform you that the claim for the ☐ injury on _____, 199___, or
☐ occupational disease as of _____, 199___, or
☐ death on _____, 199___

is **DENIED** for the following reasons:

[PROVIDE A DETAILED STATEMENT OF THE GROUNDS FOR DENYING COMPENSABILITY OF THE CLAIM OR LIABILITY FOR THE CLAIM WHERE PAYMENTS HAVE PREVIOUSLY BEEN MADE WITHOUT PREJUDICE UNDER N.C. GEN. STAT. § 97-18(d). FAILURE TO SPECIFY A PARTICULAR GROUND MAY PRECLUDE ASSERTING CERTAIN DEFENSES AT A LATER DATE PURSUANT TO N.C. GEN. STAT. § 97-18(f).]

_____
_____
_____
_____
_____
_____
_____
_____.

_____
SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR TITLE DATE

EMPLOYEE: IF YOU DISAGREE WITH THIS DENIAL, YOU ARE ENTITLED TO REQUEST A HEARING BY COMPLETING A FORM 33. IF YOU NEED ASSISTANCE YOU MAY CONTACT THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW OR TELEPHONE THE INDUSTRIAL COMMISSION AT (919) 733-0345.

EMPLOYER: A COPY OF THIS FORM SHALL BE SENT TO THE EMPLOYEE AND EMPLOYEE'S ATTORNEY OF RECORD, IF ANY. THE ORIGINAL OF THIS FORM SHALL BE SENT TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611.

FORM 62
2/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO. _____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

NOTICE OF REINSTATEMENT OF COMPENSATION PURSUANT TO N.C. GEN. STAT. § 97-32.1 OR N.C. GEN. STAT. § 97-18(b)

Compensation in the amount of $ _____ per week was reinstated on _____, 199____ pursuant to ☐ N.C. Gen. Stat. § 97-32.1

or

☐ N.C. Gen. Stat. § 97-18(b).

Give reasons for reinstatement:_____
_____
_____
_____
_____.

The employee's average weekly wage, including overtime and all allowances, was $_____, which results in a weekly compensation rate of $_____.

☐ **a.** Temporary total compensation is being paid at the compensation rate above.
☐ **b.** Temporary partial compensation is being paid in the amount of $_____.
☐ **c.** Other:_____.

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR | TITLE | DATE

EMPLOYER: THE ORIGINAL OF THIS FORM MUST BE SENT TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611. A COPY SHALL BE PROVIDED TO THE EMPLOYEE AND THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY.

FORM 63
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. FILE NO._____
CARRIER FILE NO._____
EMPLOYER CODE NO. _____
CARRIER CODE NO._____

Employee_____
Social Security No._____
Address_____
Telephone_____

Employer_____
Address_____
Telephone_____

Carrier_____
Address_____
Telephone_____

NOTICE TO EMPLOYEE OF PAYMENT OF COMPENSATION WITHOUT PREJUDICE TO LATER DENY THE CLAIM PURSUANT TO N.C. GEN. STAT. § 97-18(d)

TO EMPLOYEE,OR IN CASES OF DEATH, DEPENDENT(S) OR NEXT OF KIN:

This is to inform you with regard to your claim for the:

- ☐ injury on _____, 199___
- ☐ occupational disease as of _____, 199___
- ☐ death on _____, 199__

payments of workers' compensation benefits will be paid without prejudice to our right to later contest your claim or our liability. This notice is not an admission of liability.

Compensation may be continued during our current investigation of your claim which may take 90 days, with a possible 30 day extension. However, during this time we may accept liability, contest your claim or our liability; or by our lack of action waive our right to contest your claim or our liability.

The date on which we first had notice of your claim for compensation was_____, 199__. The first payment will be paid to you on _____, 199__. We understand that your average weekly wage, including overtime and allowances, is $ _____. The rate of compensation (66 2/3 percent of the average weekly wage) is $ _____.

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

EMPLOYER: A COPY OF THIS FORM SHALL BE SENT TO THE EMPLOYEE AND THE ORIGINAL OF THE FORM SHALL BE SENT TO: INDUSTRIAL COMMISSION, 430 NORTH SALISBURY STREET, DOBBS BUILDING, RALEIGH, NC 27611. IF YOU NEED ASSISTANCE, YOU MAY TELEPHONE THE INDUSTRIAL COMMISSION AT (919) 733-0345. FAILURE TO FILE FORM 28B rev., REPORT OF COMPENSATION AND MEDICAL COMPENSATION PAID, WITHIN SIXTEEN (16) DAYS AFTER LAST PAYMENT PURSUANT TO AN AGREEMENT OR AWARD MAY SUBJECT THE EMPLOYER OR CARRIER/ADMINISTRATOR TO A PENALTY.