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 57, 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 V. Booker
Chairman

J. Harold Davis
Commissioner

J. Randolph Ward
Commissioner
FORM 18M
3/15/95

NORTH CAROLINA INDUSTRIAL COMMISSION

Employee ____________________________
Social Security No. ____________________________
Address ____________________________
Telephone ____________________________

Employer ____________________________
Address ____________________________
Telephone ____________________________

Carrier ____________________________
Address ____________________________
Telephone ____________________________

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

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. □ 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 PHYSICIAN  PRINTED NAME  DATE

ADDRESS  CITY  STATE  ZIP
**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 .

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Signature</th>
<th>Title</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Name of Carrier/Administrator</th>
<th>Signature</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**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.

***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
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____


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.

<table>
<thead>
<tr>
<th>SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR</th>
<th>PRINTED NAME</th>
<th>TELEPHONE NUMBER</th>
<th>DATE</th>
</tr>
</thead>
</table>

SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT STOPPED, YOU SHOULD COMPLETE THIS SECTION.

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

__________________________________________________________________________
__________________________________________________________________________

2. Enclose and specify 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.

<table>
<thead>
<tr>
<th>SIGNATURE OF EMPLOYEE</th>
<th>WITNESS</th>
<th>DATE</th>
</tr>
</thead>
</table>

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.
**EVALUATION FOR PERMANENT IMPAIRMENT**

**EMPLOYEE’S WORK-RELATED INJURY WILL RESULT IN:**

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>% OF IMPAIRMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Thumb</td>
<td></td>
</tr>
<tr>
<td>2) Index Finger</td>
<td></td>
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<tr>
<td>3) Middle Finger</td>
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<tr>
<td>4) Ring Finger</td>
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<tr>
<td>5) Little Finger</td>
<td></td>
</tr>
<tr>
<td>6) Great Toe</td>
<td></td>
</tr>
<tr>
<td>7) Toes (other than great toe)</td>
<td></td>
</tr>
<tr>
<td>8) Hand</td>
<td></td>
</tr>
<tr>
<td>9) Arm</td>
<td></td>
</tr>
<tr>
<td>10) Foot</td>
<td></td>
</tr>
<tr>
<td>11) Leg</td>
<td></td>
</tr>
<tr>
<td>12) Back</td>
<td></td>
</tr>
</tbody>
</table>

**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 __________________
  - Left ear __________________
- PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS

**OTHER**
- Permanent injury to or impairment of any other organ or part of body (identify): __________________
- Disfigurement: □ Yes / □ No
- Location: □ face / □ head / □ body

**EMPLOYER:** THE ORIGINAL 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.
Rule 405

Computation of Compensation for Amputations

1. Amputation of any portion of the bone of a distal phalanx 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 (¼) of such finger or toe.

2. Amputation of any portion of the bone of the distal phalanx of a finger or toe proximal to the visible base of the nail will be considered as equivalent to the loss of one-half (½) of such finger or toe.

3. Amputation through the forearm at a point so distal to the elbow as to permit satisfactory use of a prosthesis 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 prosthesis 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

Employee_____________________________
Social Security No_____________________
Address______________________________
Telephone____________________________

Employer____________________________
Address______________________________
Telephone____________________________

 Carrier______________________________
Address______________________________
Telephone____________________________

I.C. FILE NO.__________________________
CARRIER FILE NO._____________________
EMPLOYER CODE NO.__________________
CARRIER CODE NO._____________________

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 ☐ if ☐ 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

Employee
Social Security No.
Address
Telephone

Employer
Address
Telephone

Carrier
Address
Telephone

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

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 EMPLOYER 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.
**NORTH CAROLINA INDUSTRIAL COMMISSION**

**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 ________
2. Salary ☐ was / ☐ was not continued.
3. Number of weeks temporary total from ________ through ________
4. Number of weeks temporary partial from ________ through ________
5. Number of weeks permanent partial from ________ through ________
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? ________
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

Employee ____________________________
Social Security No. ____________________
Address _____________________________
Telephone ___________________________

Employer ____________________________
Address _____________________________
Telephone ___________________________

Carrier ______________________________
Address _____________________________
Telephone ___________________________

I.C. File No. _________________________
Carrier File No. ______________________
Employer Code No. ____________________
Carrier Code No. ______________________

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

Employee
Social Security No.
Address
Telephone

Employer
Address
Telephone

Carrier
Address
Telephone

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

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 ____________, 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
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, physicians 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:

[Blank lines]

(Describe with particularity)

[Signature]
Chairman
Industrial Commission
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.

<table>
<thead>
<tr>
<th>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)</th>
</tr>
</thead>
</table>

**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**
NORTH CAROLINA INDUSTRIAL COMMISSION

Employee ____________________________
Social Security No. ___________________
Address ____________________________
Telephone __________________________

Employer ____________________________
Address ____________________________
Telephone __________________________

Carrier ______________________________
Address ____________________________
Telephone __________________________

LC. FILE NO. _________________________
CARRIER FILE NO. ___________________
EMPLOYER CODE NO. ________________
CARRIER CODE NO. _________________

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.
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).]

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

_________________________________________   Title   ____________________________

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR   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 Ruth Jones, Raleigh, NC 27611.
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

Employee ____________________________
Social Security No. __________________
Address ____________________________
Telephone __________________________

Employer ____________________________
Address ____________________________
Telephone __________________________

Carrier ____________________________
Address ____________________________
Telephone __________________________

CARRIER FILE NO. __________________
EMPLOYER CODE NO. ________________
CARRIER CODE NO. __________________

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, DOBB'S 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.