

DENIAL OF WORKERS' COMPENSATION CLAIM
(G.S. §97-18(c) AND G.S. §97-18(d))

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name		Employer's Name		() - Telephone Number	
Address		Employer's Address		City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
() - Home Telephone	() - Work Telephone	Carrier's Address		City	State Zip
- - □ M □ F	/ /	() -	() -		
Social Security Number	Sex	Date of Birth	Carrier's Telephone Number	Fax Number	
Date of Injury: _____					

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

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

is **DENIED** for the following reasons:

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR TITLE DATE

Employer/Insurance Carrier must 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).

Employee: If you disagree with this denial, you are entitled to request a hearing by submitting a Form 33. If you need assistance you may contact the Industrial Commission at the address below or telephone the Industrial Commission at (800) 688-8349.

Employer: A copy of this form shall be sent to the employee and employee's attorney of record, if any, and all known health care providers which have submitted bills to the employer/carrier. The original of this form shall be sent to the Industrial Commission at the address below.