

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 _____

Date(s) of Service _____

Total Charges for Services Provided _____

Contact Name _____

Address _____ City _____ State _____ Zip _____

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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 _____

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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 _____

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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