North Carolina Industrial Commission

EMPLOYEE'S APPLICATION FOR ADDITIONAL MEDICAL COMPENSATION (G.S. 97-25.1)

(APPLICABLE TO INJURIES BY ACCIDENT OR OCCUPATIONAL DISEASES CONTRACTED ON OR AFTER 5 JULY 1994)

IC File #____________
Emp. Code #____________
Carrier Code #____________
Employer FEIN____________

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

Employee's Name ____________________

Address ____________________

City ______ State ______ Zip ______

( ) Home Telephone ______ ( ) Work Telephone ______

Social Security Number ______ Sex ☐ M ☐ F Date of Birth ___/___/___

Employer's Name ____________________ ( ) Telephone Number ______

Employer's Address ______ City ______ State ______ Zip ______

Insurance Carrier ____________________

Carrier's Address ______ City ______ State ______ Zip ______

( ) Carrier's Telephone Number ______ ( ) Fax Number ______

SECTION A. TO BE COMPLETED BY EMPLOYEE:

1. The above-named employee claims additional medical compensation as a result of an injury by accident or an occupational disease which occurred on or by ____________ (Date) because ____________
____
(Reason for Additional Medical Compensation)
2. Additional medical and/or other supporting documentation ☐ is / ☐ is not attached (*optional*).
(Place your I.C. File # on each attachment.)

____________________ SIGNATURE OF EMPLOYEE ____________ DATE COMPLETED

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

EMPLOYEE: SEND THE ORIGINAL OF THIS FORM TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW, AND A SIGNED COPY TO THE EMPLOYER OR CARRIER/ADMINISTRATOR.

SECTION B. TREATING PHYSICIAN'S STATEMENT (OPTIONAL) :

This is to certify that:

1. I am the above-named employee's treating physician. My area of medical practice is ____________________, and my treatment of the employee began on ___________. (mo/day/yr)
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 ______

MAIL TO: ***NCIC – EXECUTIVE SECRETARY***
4333 MAIL SERVICE CENTER
RALEIGH, NC 27699-4333
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FORM 18M