

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

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

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

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		
XXX-XX- Last 4 Digits of SSN			☐ M ☐ F Sex	/ / Date of Birth	() - Carrier's Telephone Number	City	State	Zip
Date of Injury:						() - Fax Number		

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
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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.

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
[HTTP://WWW.IC.NC.GOV/DOCFILING.HTML](http://www.ic.nc.gov/docfiling.html)