North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

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)

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
( ) Home Telephone ( ) Work Telephone	Carrier's Address City State Zip
XXX-XX- Last 4 Digits of SSN ☐ M ☐ F Sex / / Date of Birth	( ) 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 AND ANY SUPPORTING DOCUMENTATION TO THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOM OF THIS FORM AND SEND A 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

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
4333 MAIL SERVICE CENTER
RALEIGH, NC 27699-4333

HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 18M