

## N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

### IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

#### The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website [www.ic.nc.gov](http://www.ic.nc.gov) or by calling the Help Line.
- Your employer's workers' compensation insurance carrier is \_\_\_\_\_.
- The insurance policy number is \_\_\_\_\_.
- Your employer's workers' compensation insurance policy is valid from \_\_\_\_\_ until \_\_\_\_\_.

**For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.**

#### The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed \$2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

**For assistance with Safety Education Training contact:**

**Director of Safety Education at (919) 807-2602 or [safety@ic.nc.gov](mailto:safety@ic.nc.gov)**

**NORTH CAROLINA INDUSTRIAL COMMISSION**

**4335 MAIL SERVICE CENTER**

**RALEIGH, NORTH CAROLINA 27699-4335**

**Website: [www.ic.nc.gov](http://www.ic.nc.gov)**



# EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. FEIN \_\_\_\_\_

Carrier FEIN \_\_\_\_\_

Carrier File # \_\_\_\_\_

### To the Employer:

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. **The filing of this report is required by law.**

This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

### To the Employee:

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

### 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
Social Security Number		Sex	Date of Birth	Carrier's Telephone Number	Fax Number

<b>Employer</b>	1. Give nature of employer's business
	2. Location of plant where injury occurred County _____ Department _____ State if employer's premises Y
	3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. 5. Was employee paid for entire day Y 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. 7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____
<b>Person Injured</b>	9. Occupation when injured _____
	10. (a) Time employed by you _____ (b) Wages per hour \$ _____
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____ (d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per _____
	12. Describe fully how injury occurred and what employee was doing when injured:  (Statement made without prejudice and without vouching for correctness of information)
<b>Cause And Nature Of Injury</b>	13. List all injuries and specify body part involved (e.g. right hand or left hand):  14. Date & hour returned to work / / at : .M. 15. If so, at what wages \$ _____ per _____ 16. At what occupation _____ 17. Employee's salary continued in full? Y N 18. Was employee treated by a physician Y N
	<b>Fatal Cases</b>
	19. Has injured employee died Y 20. If so, give date of death (Submit Form 29) / /

Employer name \_\_\_\_\_ Date Completed / /  
Signed by \_\_\_\_\_ Official Title \_\_\_\_\_

### OSHA 301 Information:

Case Number from Log: _____	Date Hired: / /	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility: _____	Address: Street/City/Zip/Telephone _____		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

**SELF-INSURED EMPLOYER OR CARRIER MAIL TO:**  
**NCIC - CLAIMS ADMINISTRATION**  
**4335 MAIL SERVICE CENTER**  
**RALEIGH, NORTH CAROLINA 27699-4335**  
**MAIN TELEPHONE: (919) 807-2500**  
**HELPLINE: (800) 688-8349**  
**WEBSITE: HTTP://WWW.IC.NC.GOV/**

## IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

## IMPORTANT INFORMATION FOR EMPLOYEE

### Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

### Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

**FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349**

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON  
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

## INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

### Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

### Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA  
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)  
O SU NÚMERO DE SEGURO SOCIAL.

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION  
4335 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-4335  
MAIN TELEPHONE: (919) 807-2500  
HELPLINE: (800) 688-8349  
WEBSITE: [HTTP://WWW.IC.NC.GOV/](http://www.ic.nc.gov/)



## Injured Worker's First Fill Prescription Form

Administered by CorVel (800) 563-8438

**Injured Worker's Name:** \_\_\_\_\_

**SS#:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_

### INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, **please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by GUIDE ONE.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Information Sheet to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14 day supply of medications.

### PHARMACIST INSTRUCTIONS:

Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

<b>CORVEL</b>		<b>CVS CAREMARK</b>
<b>BIN:</b>	<b>004336</b>	
<b>PCN:</b>	<b>ADV</b>	
<b>RxGroup:</b>	<b>RXFFWC491</b>	
<b>Member ID:</b>	<b>See below to generate ID</b>	

**To Generate Member ID:** The Injured Worker's nine digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit Member Identification number when processing their First Fill Prescription: XXXXXXXXXXXMMDDYYYY

\*\*\*Please contact CorVel Pharmacy Solutions at (800) 563-8438 for assistance with claims processing\*\*\*

There are over 70,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 to locate a Pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

