STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

WORKERS' COMPENSATION COMPLAINT

1. Type of injury: Accidental Work Injury/Occupational Disease
2. Worker's full name: _____
   Mailing address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail address: _____
   Worker's highest level of school completed: _____
   Worker's date of birth: _____ Age: _____ Sex: ☐ M ☐ F
   Worker's Social Security Number: _____
3. Full name of Employer: _____
   Employer's address: _____
   City/State/Zip: _____
   Telephone: _____
   Email address: _____
4. Insurance Carrier: _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail address: _____
5. Date of accident: _____
   City and county of accident: _____
   How did the accident occur: _____
   Nature of injury: _____

Part(s) of body injured: _____

First date Worker was unable to perform job duties: _____

6. Worker's job at time of accident: _____

   Worker's average weekly wage: _____ ☐ To be determined/disputed

   Worker's Weekly compensation rate: _____ ☐ To be determined/disputed

7. Doctor's name: _____

   Mailing address: _____

   City/State/Zip: _____

   Telephone: _____

8. Doctor who set maximum medical improvement: _____

   Date of maximum medical improvement: _____ ☐ Unknown/To be determined

   Impairment rating: _____ Date assessed: _____ ☐ Unknown/To be determined

   Has Worker been released back to work by a Doctor? ☐ Yes ☐ No

   If yes, please indicate the date Worker was released to work: _____

   Has Worker returned to any work since the accident? ☐ Yes ☐ No

   If yes, please indicate date Worker returned to work: _____

9. Current employer's name: _____

   Mailing address: _____

   City/State/Zip: _____

10. Medicare eligibility:

    Is Worker a current Medicare beneficiary? ☐ Yes ☐ No

    Has Worker applied for Social Security Disability benefits in the past 5 years? ☐ Yes ☐ No

    Has Worker been diagnosed with end stage renal disease? ☐ Yes ☐ No (See 42 U.S.C. § 426-1)

11. Benefits or relief sought by Worker:

    ☐ All benefits entitled to under the New Mexico Workers' Compensation Act

    ☐ Temporary total disability ☐ Death benefits

    ☐ Permanent total disability ☐ Attorney fees

    ☐ Permanent partial disability ☐ Disfigurement

    ☐ Safety device increase (name device): _____

    ☐ Mental impairment: ☐ Primary ☐ Secondary

    ☐ Medical benefits (list here or attach unpaid bills): _____

    ☐ Determination of: ☐ Bad Faith/Unfair Claims Processing ☐ Fraud or ☐ Retaliation

    ☐ Other (specify):

12. Complaints by Employer:

☐ Determination of compensability/benefits

☐ Safety device decrease (name device):_____

☐ Reimbursement right

☐ Credit for overpayment

☐ Suspension or reduction of benefits (state grounds):

☐ Other (specify):

13. State all reasons supporting this complaint (be specific; use additional pages, if necessary):

14. Is an interpreter needed for the hearings on this complaint? ☐ Yes ☐ No

If yes, what language? _____

(Employer will pay for cost of interpreter)

15. Do you have the equipment needed to attend mediation and hearings via online video link or telephonically? ☐ Yes ☐ No

16. If not, the WCA will provide the equipment. Which office is closest to you?

☐ Albuquerque ☐ Farmington ☐ Hobbs ☐ Las Cruces ☐ Las Vegas ☐ Roswell ☐ Santa Fe

_____ _____

Filing party signature Date Attorney's signature Date

_____ _____

Print name Print name

_____

Filing party /attorney's address

_____

Filing party /attorney's city, state, zip

_____

Filing party /attorney's telephone

_____

Filing party / attorney's e-mail address for service

INSTRUCTIONS FOR USE: A Summons for each responding party shall be filed with the Complaint.

If the Worker is filing this Complaint, the Worker shall also complete and attach the Worker's Authorization for Use and Disclosure of Health Records.

Parties with questions may call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

SUMMONS FOR WORKERS' COMPENSATION COMPLAINT

TO: _____ _____

_____ _____

_____ _____

_____ _____

GREETINGS:
You are directed to serve a written response to the Workers' Compensation Complaint **not less than five (5) days prior to the mediation conference**, and file the same, as provided by law.

You are notified that, unless you serve and file a responsive pleading, the filing party may apply to the Workers' Compensation Administration for the relief demanded in the Workers' Compensation Complaint.

Worker or filing party's representative:

_____

Address of Worker or filing party's representative:

_____

_____

WITNESSED AND SEALED BY THE CLERK OF THE WCA

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS

Worker/Patient FULL NAME: _____ DOB: _____ SSN: XXX-XX-_____

FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with Section 52-10-1 NMSA 1978, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any workplace injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed $1.00 per page for the first ten (10) pages or up to twenty-cents ($0.20) for each page thereafter. A copy of this authorization may be used as an original.

Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (Worker's Name) _____, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:		
Address:		
Telephone No.:		

I authorize the following records released (check box, as appropriate): ☐ **ALL RECORDS** ☐ **SPECIFIC DATES**

provide a date range for records authorized to be released _____

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (check any that may apply).

☐ Treatment for alcohol and/or substance abuse ☐ Sexually transmitted diseases ☐ HIV or AIDS

☐ Behavioral or Mental Health, including Psychiatric or Psychological ☐ Records of the Department of Health Medical Cannabis Program

_____ _____

Signature of Worker/Patient/Personal Representative Date

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be ☐ Picked Up ☐ Mailed ☐ Emailed ☐ Faxed ☐ Other (specify):

_____

Authorized Recipient/s:		
Address:		
Telephone No.:		
Fax/Email:		

EXPIRATION and CONDITIONS

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

_____ _____

Signature of Worker/Patient Date

_____ _____

Signature of Personal Representative (if any) Date

_____ _____

Printed Name of Personal Representative Relationship to Worker/Patient