STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

____, WCA No.:_______________
Worker,

v.

____, and
____,
Employer/Insurer.

HEALTH CARE PROVIDER DISAGREEMENT FORM

A disagreement has arisen over the selection of Health Care Provider (HCP), or provision of health care services pursuant to 11.4.4.12 NMAC.

Check the appropriate reason for the Health Care Provider disagreement.

____ Applicant disagrees with the Notice of Change of Health Care Provider pursuant to 11.4.4.12(F)(1) or (F)(2) NMAC.: A Notice of Change of HCP was served by:
___ Worker ___ Employer on ________________ ____, 2*0*____. (Attach a copy of the Notice of Change of Health Care Provider)

____ Applicant disagrees that the authorized HCP is providing the worker reasonable and necessary medical care and requests a change in HCP. Pursuant to 11.4.4.12(L) NMAC, the applicant bears the burden of proof to show that the worker is not receiving reasonable and necessary medical care or the request will be denied. Applicant may suggest an alternate HCP pursuant to 11.4.4.12(K)(2) NMAC:

Applicant objects to the authorized HCP for the following specific reasons (11.4.4.12(K)(1) NMAC):

____
Signature of filing party

Worker's Name: ______________________________
SSN: ____
Date of Accident: _____________________________
Mailing Address: ______________________________
City/State/Zip:________________________________
Telephone: ___________________________________
E-mail address for service: ______________________

Worker's Rep.: _______________________________
Address: ____________________________________
City/State/Zip: _______________________________
Telephone: __________________________________
E-mail address for service: ______________________

Employer:____________________________________
Address:_____________________________________
City/State/Zip:_______________________________
Telephone:___________________________________
E-mail address for service: ______________________

Insurer: _____________________________________
Address: ____________________________________
City/State/Zip: _______________________________
Telephone: __________________________________
E-mail address for service: ______________________

Employer's Rep.: ______________________________
Address:_____________________________________
City/State/Zip:_______________________________
Telephone:__________________________________
E-mail address for service: ______________________