STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

APPLICATION TO DIRECTOR

1. Type of injury: ☐ Accidental Work Injury ☐ Occupational Disease
2. Worker's full name: _____
   Mailing address: _____
   City/State/Zip: _____
   Telephone: _____
   Worker's date of birth: _____ Age: _____ Sex: ☐ M ☐ F
   Worker's social security no.: _____
3. Full name of employer: _____
   Employer's address: _____
   City/State/Zip: _____
   Telephone: _____
   Email address for service: _____
4. Insurance carrier: _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail address for service: _____
5. Health Care Provider (*if applicable*): _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____

6. Date of accident or death: _____

   City and county of accident: _____

   Nature of the injury: _____

   Worker's job at time of accident:_____

   Weekly compensation rate: _____

7. What benefit or relief is being sought?

   ☐ Judge assignment disputes, pursuant to, Sections 52-5-2 NMSA 1978, and 52-5-5, and NMAC 11.4.4.13(A).

   ☐ Hearing on an untimely rejection of a recommended resolution, pursuant to, Section 52-5-5 NMSA 1978.

   ☐ Request to withdraw an acceptance of a recommended resolution, pursuant to Section 52-5-5 NMSA 1978,

   ☐ Appointment of Recipient of Benefits on behalf of a minor child or incompetent worker, pursuant to, Section 52-5-11 NMSA 1978 and 11.4.4.11 NMAC.

   ☐ Approval of an out of state health care provider (affidavit of provider shall be attached), pursuant to Section 52-4-1 NMSA 1978 and 11.4.7.10 NMAC.

   ☐ Attorney withdrawal, pursuant to 11.4.4.14 NMAC.

   ☐ WCA medical case management or utilization review dispute, pursuant to Sections 52-4-2 NMSA 1978 and 52-4-3, and 11.4.7.12 NMAC.

   ☐ Other (specify):

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

9. Is a hearing requested? ☐ Yes ☐ No

If yes, the filing party shall submit the mandatory forms. Request for Setting and with the Summons, if applicable.

10. Is an interpreter needed for the hearings on this application? ☐ Yes ☐ No

If yes, what language? _____
(Employer will pay for cost of interpreter.)

_____ _____

Signature Date Print name

_____
Filing party's address

_____
Filing party's city, state, zip

_____
Filing party's telephone

_____
Filing party's e-mail address for service

INSTRUCTIONS FOR USE: A Request for Setting and a Summons for each responding party shall be filed with the application, if a summons has not been previously issued. If the Worker is filing this application, the Worker shall also attach 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
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SUMMONS FOR APPLICATION TO DIRECTOR

To: _____ _____

_____ _____

_____ _____

_____ _____

GREETINGS:

You are directed to appear before the Workers' Compensation Administration and respond to this Application. If you choose to file a written response to this Application, you must file your response with the Workers' Compensation Administration Clerk of Court **within 10 days of receipt of this Application.**

If you fail to appear and respond, the Workers' Compensation Administration may enter a judgment against you for the relief demanded in the Application.

Worker or filing party's representative:

_____

Address of Worker or filing party's representative:

_____

_____

WITNESSED AND SEALED BY THE CLERK OF THE WCA

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

REQUEST FOR SETTING

1. WCA Judge assigned: _____
2. Are any other hearings currently set? ☐ Yes ☐ No
   If yes, please indicate the date of the hearing: _____
3. Specific matter to be heard: _____
4. Time required for hearing: _____
5. Is an interpreter required? ☐ Yes ☐ No
   (Employer/Insurer is responsible for making arrangements for the interpreter.)
6. Is telephonic appearance being requested? ☐ Yes ☐ No
   (Employer/Insurer is responsible for arranging the conference call.)

_____
Signature

_____
Print name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
E-mail address for service

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

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ORDER GRANTING APPROVAL OF OUT OF STATE HEALTH CARE PROVIDER

THIS MATTER having come before the Director pursuant to Section 52-4-1(Q), NMSA 1978, and having reviewed the Application to Director and Affidavit of the proposed out of state health care provider (applicant), the Director **FINDS;**

1. The Applicant is licensed in the State of _____ and said license is in good standing.

2. The Applicant has satisfied the Director that authorization to provide health care to the worker in this case will not unduly disrupt the operation of the New Mexico workers' compensation system.

3. Good cause exists to approve Applicant as an out of state health care provider.

IT IS THEREFORE ORDERED as follows:

1. Subject to the provisions of Section 52-1-49, NMSA 1978, _____ is approved as an out of state health care provider to treat worker in this workers' compensation case.

2. As an approved out of state health care provider, _____ is subject to the New Mexico Workers' Compensation Act and its rules and regulations, including the health care provider fee schedule.

3. The Director retains the right to revoke, suspend, or place conditions on this approval without cause.

4. If this out of state health care provider's medical license is suspended or revoked, this approval shall be automatically revoked and effective as of the day of suspension or revocation.

_____
HEATHER JORDAN
WCA Director

Approved as to form:

_____
Signature of Worker

_____
Signature of Insurer Attorney/Adjuster

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
OUT OF STATE HEALTH CARE PROVIDER AFFIDAVIT

1. I, being duly sworn or affirmed, state: I am licensed as a _____, in the State of _____, and my license to practice is currently in good standing;

2. I acknowledge that I have treated or intend to treat injured worker _____(name) involved in a workers' compensation claim governed by the laws of New Mexico;

3. I agree to be bound by the Workers' Compensation Act of the State of New Mexico and all Workers' Compensation Administration (WCA) rules and regulations, including the WCA Health Care Provider Fee Schedule unless I have separately negotiated fees with the payer prior to rendering services; and

4. I understand that if my license to practice in _____ is suspended or revoked, my designation as an approved health care provider is automatically revoked.

_____
Signature

_____
Health Care Provider – Printed Name

_____
Address

_____
City/State/Zip

_____
Telephone

ACKNOWLEDGMENT

STATE OF _____)
) ss.
COUNTY OF _____)

Subscribed and sworn or affirmed to before me this _____ day of _____, 20_____.

_____
Notary Public

My commission expires:

_____

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 work place 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

Rev. 2/19
11.4.4.9 NMAC