NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
FORM LETTER TO HEALTH CARE PROVIDER

INSTRUCTIONS:
Please fill out and return this form promptly. Base your answers on a reasonable medical probability. Answer all questions which you believe to be pertinent to the Worker's claim. Please give one copy of the form to the Worker. The maximum allowable fee for completion of this form is set forth in the health care provider fee schedule. The bill for completion of this form should be sent to the claims administrator.

Return this completed form letter to: Name: _____

Address: _____

_____

TO: **Health Care Provider:** Name: _____

Address: _____

_____

RE: **Worker:** Name: _____ WCA# _____
Last, First

DOB: _____ SSN (last four digits): XXX-XX- _____

1. Date of Injury/Occurrence: _____
2. Date that the Worker was first seen/treated: _____
3. Date that the Worker was last seen/treated: _____
4. Diagnosis of the condition(s) for which you have treated the Worker:

5. In your opinion, are the conditions or complaints for which you have treated the Worker causally-related to an on-the-job injury or exposure? ☐ YES ☐ NO
6. Is the Worker able to return to work? ☐ YES ☐ NO

   If no, when do you anticipate return to work? _____
7. Indicate the period of time, if any, the Worker has been unable to work: _____
8. Has the Worker reached maximum medical improvement (MMI)? ☐ YES ☐ NO
   a. Date of MMI:_____
   b. Anticipated date of MMI: _____
9. If the Worker has reached MMI and you have already assessed Worker's impairment, please indicate your opinion as to the percentage of the Worker's anatomical or functional abnormality as of the date of MMI:
   a. Percentage of impairment, if any _____
   b. Whole body or body part: _____
   c. Indicate which edition of *AMA Guides* used: _____
   d. AMA page numbers: _____

10. Has a physical capacities assessment of functional capacity evaluation been performed? ☐ YES ☐ NO

    Performed by: _____

    Date of evaluation: _____

11. Does the Worker have work restrictions? ☐ YES ☐ NO

    If yes, please indicate any work restrictions on the chart below:

	Never	**Occasionally**	**Frequently**
Lift **over** 50lbs			
Lift **up to** 50 lbs.			
Lift **up to** 25 lbs.			
Lift **up to** 20 lbs.			
Lift **up to** 10 lbs.			
Lift **up to** 5 lbs.			
Walking			
Standing			
Sitting			
Push / Pull **ARM** Controls			
Push / Pull **LEG** Controls			

12. Are the above stated work restrictions permanent? ☐ YES ☐ NO

    If no, how long do you anticipate the Worker will have the stated restrictions? _____

13. Does the Worker have activity restrictions? ☐ YES ☐ NO

    If yes, please describe any additional activity restrictions:

14. Have you referred the Worker to other health care providers, hospitals or institutions? ☐ YES ☐ NO

    If yes, please provide name(s):

15. Other remarks:

I hereby affirm that the foregoing responses or opinions are true and correct to a reasonable medical probability.

Physician's signature: _____ Date: _____

Physician's printed name: _____

Address: _____

City/State/Zip: _____

Telephone: _____