

**STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION**

_____, WCA No.: _____
Worker,
v. _____, and
Uninsured Employer,
STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND,
Statutory Third Party.

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: _____
E-mail address: _____
4. Statutory Third Party: STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND _____
Address: 2410 Centre Avenue SE _____
City/State/Zip: Albuquerque, NM 87106 _____
Telephone: 505-841-6000 _____
E-mail address: WCA-UEF@wca.nm.gov
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 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): _____

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.

DISCLAIMER: The WCA provides a Spanish to English translation of this Complaint as an aid to the litigation process. No WCA translation shall be construed as an official translation.

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
Uninsured Employer
STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND,
Statutory Third Party.

SUMMONS FOR WORKERS' COMPENSATION COMPLAINT

_____ STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND
2410 Centre Avenue SE
Albuquerque, NM 87106
WCA-UEF@wca.nm.gov

GREETINGS:

You are directed to serve a written response to the Workers' Compensation Complaint **not less than five (5) days prior to your 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: _____
FOR WCA REFERENCE ONLY: Date/s of Injury: _____

DOB: _____ SSN: XXX-XX-_____
WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with NMSA 1978, § 52-10-1, 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.

RELEASE OF HEALTH CARE RECORDS

I, (Print 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:	_____

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: (initial 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:	UEF/Hospital Services Corp
Address:	P.O. Box 92200
	Albuquerque, NM 87199-2200

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 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