State of New Mexico
**Workers' Compensation Administration**

**Michelle Lujan Grisham**
Governor

**Alexis Armijo**
Acting Director

**NM Workers' Compensation Administration**
**Medical Cost Containment Bureau – (505) 795-5752 or toll free at 1-800-255-7965**
**Request for Billing Dispute Review**

**Please attach the following information: Corresponding HCFA(s) or UB form; payor's explanation of benefits (EOBs); and all supporting documentation such as medical records and/or prior approval.**

Submit request and material via email to: WCA-MCC@wca.nm.gov or Mail: P.O. Box 27198, Albuquerque, NM 87125-7198 or
In Person: 2410 Centre Ave SE, Albuquerque, NM 87106

Please check the box that best describes the nature of the dispute, include attachments as listed below and include the expected payment. ***Please fill in required information**.

❑ No response to bill submission
- ✓ HCFA (first and reconsideration)
- ✓ Medical documentation
- ✓ Proof of timely filing
- ✓ EOBs
- ✓ Correspondence with payor
- ✓ Expected Payment $: _____

❑ Denied payment or partial payment
- ✓ HCFA (first and reconsideration)
- ✓ Medical documentation
- ✓ Proof of timely filing
- ✓ EOBs
- ✓ Correspondence with payor
- ✓ Appeal
- ✓ Response to appeal/EOB, if issued
- ✓ Referral, if applicable
- ✓ Expected Payment $: _____

Injured Worker Name: _____

Health Care Provider: _____

❑ Other:

_____

_____

_____

_____

_____

Date of Request: _____ WCA No: _____
Requested By: _____ Phone No: _____
Email: _____ Health Care Provider: _____

**Injured Worker Information**

Name: _____ Attorney: _____
Employer: _____ Firm: _____
Home Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Phone No: _____ Phone No: _____
Email: _____ Email: _____
DOB: _____ Social Security #: _____
WCA Claim Number: _____

**Payor Information**

Name: _____ Attorney: _____
Adjuster Name: _____ Firm: _____
Adjuster Email: _____ Address: _____
Home Address: _____ City/State/Zip: _____
City/State/Zip: _____ Phone No: _____
Phone No: _____ Email: _____
Insurer Claim Number: _____

By checking the box below and submitting this form, the provider attests that all attachments (including, but not limited to medical records, billing forms, prior authorizations, etc.) are the exact reproductions of the documents previously submitted to the workers' compensation payer for reimbursement. The provider also attests that any amendments to medical records comply with Rule 7 11.4.7.8 NMAC GROUND RULES FOR BILLING AND PAYMENTS and have been made prior to the initial bill submission with the workers' compensation payer.

Failure to comply with the above may result in closure of the dispute with prejudice, the inability to utilize the MCC Bureau's Billing Dispute Resolution Process in the future (the provider would be limited to requesting a hearing in front of the NM Workers' Compensation Administration, and/or referral to another regulatory body such as the NM WCA Enforcement Bureau.

❑ I accept these terms and conditions