



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: _____

☐ Reason for Dispute:

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Date of Request: _____
Requested By: _____
Email: _____

WCA No: _____
Phone No: _____
Health Care Provider: _____

Injured Worker Information

Name: _____
Employer: _____
Home Address: _____
City/State/Zip: _____
Phone No: _____
Email: _____
DOB: _____
WCA Claim Number: _____

Attorney: _____
Firm: _____
Address: _____
City/State/Zip: _____
Phone No: _____
Email: _____
Social Security #: _____

Payor Information

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

Attorney: _____
Firm: _____
Address: _____
City/State/Zip: _____
Phone No: _____
Email: _____

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