STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____,
Uninsured Employer,

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 No.: (___) ___ _____
3. Worker's date of birth: _____/_____/_____ Age: ____ Sex: ____M ____F
4. Worker's Social Security Number: _____-_____-_____
5. Full Name of Employer: _____
   Employer's personal name: _____ _____
   Employer's Address: _____ _____
   City/State/Zip: _____
   Telephone No.: (___) _____ _____
6. Statutory Third Party; New Mexico Uninsured Employers' Fund
   Address: 2410 Centre Avenue, SE
   City/State/Zip: Albuquerque, New Mexico 87106
   Telephone No.: (505) 841-6000
7. Date of Accident: _____
   a. City and County of accident: _____
   b. Worker's job at time of accident: _____
   c. Worker's average weekly wage: _____
   d. Weekly compensation rate: _____
   e. How did the accident occur: _____
   f. Nature of the injury: _____
   g. Part(s) of the body injured: _____
   h. Name and address of treating Doctor(s):_____
   i. First date Worker was unable to perform job duties: _____
   j. Date of maximum medical improvement: _____
   k. Impairment rating: _____Date assessed: _____
      Doctor's Name: _____
      _____
   l. Has Worker been released to work by a Doctor? ___ Yes ___ No [check one]
      If yes, please indicate the date Worker was released to work:_____
   m. Has Worker returned to work since the accident? ___Yes ___ No [check one]
      If yes, please indicate the date Worker returned to work: _____
   n. Name and address of current Employer: _____
      _____
      _____
   o. Highest level of school completed by Worker: _____

8. a. What benefit or relief is being sought?

1. Complaints by Worker:

___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):_____

2. Complaints by Employer:

___Determination of Compensability/Benefits
___Safety Device Decrease (name device):_____
___Reimbursement Right
___Credit for Overpayment
___Suspension or Reduction of Benefits (state grounds):_____
_____
Other (specify):_____

b. State all reasons supporting this complaint (be specific; use additional pages, if necessary):
_____

_____

_____

9. Is an interpreter needed for the hearings on this complaint? ___Yes ___ No.
If yes, what language? _____.
If you have questions, call 1-800-255-7965, Mediation Bureau.

10. Medicare Eligibility:
a. Is Worker a current Medicare beneficiary? ___ Yes ___ No
b. Has Worker applied for Social Security Disability benefits in the past 5 years? ___ Yes___ No
c. Has Worker been diagnosed with End Stage Renal Disease? ___ Yes ___ No
(*See* 42 USC 426-1)

_____ _____
Filing Party Signature Attorney's Signature

_____ _____
Date Filing Party /Attorney's Name

_____
Filing Party /Attorney's Address

_____
Filing Party /Attorney's City, State, Zip

_____
Filing Party /Attorney's Telephone & Fax Number

INSTRUCTIONS FOR USE: A Summons for each responding party and insurer shall be filed with the Complaint. If the Worker is filing this Complaint, the Worker shall also attach the 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.

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 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:	**NM Uninsured Employers' Fund or its TPA, CCMSI.**	**Employer:**
Address:		
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 NOTIFIYING 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

Revised 7/13/16

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____,
Worker,

v. **WCA No.:_____**

_____,
Uninsured Employer,

v.

State of New Mexico Uninsured Employers' Fund,
Statutory Third Party.

SUMMONS FOR WORKERS' COMPENSATION COMPLAINT

TO: State of New Mexico Uninsured Employers' Fund _____
2410 Centre SE _____
Albuquerque, New Mexico 87106 _____

GREETINGS:

You are directed to serve a written response to the Workers' Compensation Complaint **not less than five (5) days prior to the mediation conference**, and file the same, as provided by law.

You are notified that, unless you serve and file a responsive pleading or motion, 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

(SEAL)

By:_____

Date:_____

(EACH ADVERSE PARTY MUST BE NAMED IN THE SUMMONS)

Uninsured Employers' Fund Claims Questionnaire

INSTRUCTIONS FOR USE:

1. An injured worker should not file a complaint naming the "Uninsured Employers' Fund" unless the worker suspects his or her employer did not have worker's compensation insurance at the time of the workplace accident.
2. In order to evaluate a claim for benefits from the UEF, the injured worker **must** complete this questionnaire. Failure to complete this questionnaire may delay processing the claim and may result in denial of the claim.
3. The completed questionnaire must be mailed to the UEF, along with an endorsed copy of the Worker's workers' compensation complaint.
4. An injured worker who does not have an attorney may ask a WCA Ombudsman for assistance in completing the complaint form and this questionnaire.

Worker's Name: _____

Date of accident: _____

1. Before you were hired by this employer, did you have your own business?
   □ Yes □ No
   If so, what type of business? _____

2. Either before or at the time you were hired by employer, did you hold a NM construction industry license? □ Yes □ No

3. What type of business was your employer involved in? _____

4. Date of hire: _____

5. When you were hired, did you fill out a written job application? □ Yes □ No

6. Name and phone number of person who hired you:_____

7. Were you hired:
   □ to perform a one-time job with an ending date?
   □ for continuous work without an end date?

8. What were your hours of work? (not including your lunch hour) _____

9. What were your work days? _____

10. Who set the work hours? _____

11. Were you paid □ by the hour, □ by the day, □ by the job?

12. What was your rate of pay? _____
    Who determined the pay rate? _____

13. As a part of your wages, did your employer provide you with housing? □Yes □No

14. Were taxes deducted from your pay? □ Yes □ No

15. Were you paid □ by check
□ or in cash?

16. Were you provided with □ a W-2 form for federal income taxes?
□ a 1099 Form for federal income taxes?

17. How long had you worked for employer before the accident?_____

18. What were your job duties? _____
_____
_____

19. Did your employer supervise your work? □ Yes □ No
[If "no" who supervised your work? _____

20. Who provided tools, equipment and materials to do your job? □ You □ Employer

21. Who provided your transportation to work? □ You □ Employer

22. While you were employed by employer, did you have other outside jobs? □ Yes □ No
If yes, what type of work did you do? _____
If yes, how many hours did you work per week? _____
What was your rate of pay at the outside job? _____

23. Besides you, how many other workers did your employer have at the time of your accident? _____
How were they paid? □ Cash □ Check

24. List the names and phone numbers of other workers who were working for your employer.

Name	**Phone Number**
_____	_____
_____	_____
_____	_____

25. Since your job accident, have you received State of NM Unemployment Benefits? _____

26. If you were a farm/ranch laborer at the time your job accident, state the name and address of the farm/ranch you were working at:_____
_____.

_____ OR _____
Worker's Signature Attorney's Signature

_____ _____
Date Date