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: edwarda.montoya@state.nm.us
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: ____

Worker's weekly compensation rate: ____

7. Doctor's name: ____

Mailing address: ____

City/State/Zip: ____

Telephone: ____

8. Doctor who set maximum medical improvement: ____

Date of maximum medical improvement: ____

Impairment rating: ___________________ Date assessed: ______________________________________

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. Is an interpreter needed for hearings on this complaint? ____ Yes ____ No

If yes, what language? ____

(Employer will pay for cost of interpreter.
If you have questions, call 1-800-255-7965, WCA Mediation Bureau.)

11. 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)

12. Benefits or relief sought by Worker:

____ Temporary total disability

____ Permanent total disability

____ Permanent partial disability

____ Death benefits

____ Attorney fees

____ 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): ____

13. 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):____
____

14. State all reasons supporting Employer's complaint (be specific; use additional pages, if necessary):
____
____
____
____
____
____
____
____

____	____
Filing party signature Date	Attorney's signature Date
____	____
Print name	Print name
	____
	Filing party /attorney's address
	____
	Filing Party /attorney's city, state, zip
	____
	Filing party /attorney's telephone
	____
	Filing party / attorney's e-mail address for service

INSTRUCTIONS FOR USE: A Summons for each responding party shall be filed with this 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.

Parties with questions may call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.

New Mexico Workers' Compensation Administration
Questionnaire for Workers Naming the Uninsured Employers' Fund in their Complaint

Worker: you should name the "Uninsured Employers' Fund" as a party to your complaint if you suspect or know your Employer did not have workers' compensation insurance at the time of your job accident. This questionnaire must be completed and filed together with your complaint for benefits with the WCA Clerk's Office. If you do not have a lawyer, you may ask a WCA Ombudsman for help with these questions as well as assistance in completing your complaint form.

Worker's full 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 and/or a food allowance: __ Yes __ No

14. Were taxes deducted from your pay: __ Yes __ No

15. Were you paid by: ___ Check ___ 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 working for 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(s): ____

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: __ Yes __ No

____ ____

Worker's Signature Date Attorney's Signature Date

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 Section 52-10-1 NMSA 1978, 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.
Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (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:		
Telephone No.:		

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: (check 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.	
Address:		
Telephone No.:		
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 THAT 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

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_________________________
____	edwarda.montoya@state.nm.us

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