STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

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: _____

   Email address: _____
4. Insurance Carrier: _____

   Address: _____

   City/State/Zip: _____

   Telephone: _____

   E-mail address: _____
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 the 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 the date Worker was released to work: _____

   Has Worker returned to any work since the accident? ____ Yes ____ No

   If yes, please indicate the date Worker returned to work: _____

9. Current employer's name: _____

   Mailing address: _____

   City/State/Zip: _____

10. Is an interpreter needed for the 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

_____
Print name

_____
Attorney's signature Date

_____
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 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.

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