NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Instructions for Director's Determination/Billing Dispute

Please attach the following information:
(1) the corresponding HCFA or UB form;
(2) the payor's explanation of benefits (EOBs); and
(3) All supporting documentation.

Instructions for Case Management Request

Please submit the last year of medical records in chronological order along with the Case Management Request Form

STATE OF NEW MEXICO
Workers' Compensation Administration

Please send Request and required records to:

Medical Cost Containment Bureau

Via fax: (505) 841-6078

Via email: WCA-MCC@state.nm.us

Via US Mail to: PO Box 27198, Albuquerque, NM 87125-7198

In person: 2410 Centre Ave SE, Albuquerque NM 87106

Instructions for Utilization Review Submission

Please submit the following information in chronological order:

A copy of all medical reports, test results, notes, referrals, consultations, IMEs, FCEs and any second opinions. This should include both hospital and clinic records, as well as any diagnostic test results.

PLEASE DO NOT INCLUDE : Copies of billing statements, comments or instructions directed to the Reviewer.

If you have any questions,
please contact the Worker's Compensation Administration
Medical Cost Containment Bureau

(505) 841-6000 or toll-free at 1-800-255-7965

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Request for Director's Determination
Billing Dispute, Case Management or Utilization Review

PURPOSE OF REQUEST: (check appropriate box)	Billing Dispute:		Case Management:		Utilization Review:	

Date of Request:		WCA#		Request Made By:	

HEALTH CARE PROVIDER INFORMATION

Health Care Provider:			Contact:	
Phone:		Fax:	Email:	

PAYOR INFORMATION

Insurer:		Attorney:	
Adjuster:		Firm:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	
Employer/Occupation:			

INJURED WORKER INFORMATION

Name:				Attorney:	
Address:				Firm:	
				Address:	
Phone:					
Date of Birth:		Date of Injury:		Phone:	
Social Security Number:		Currently Working?		Fax:	
Email:				Email:	

BILLING DISPUTE INFORMATION

Amount Billed:		Amount Paid:		Amount Disputed:	

DESCRIBE REASON FOR REQUEST