

**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: WCA-UEF@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. 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
11. Has Worker been diagnosed with end stage renal disease? ____ Yes ____ No (See 42 U.S.C. § 426-1)

11. Benefits or relief sought by Worker:

- | | |
|---|---|
| <input type="checkbox"/> Temporary total disability | <input type="checkbox"/> Death benefits |
| <input type="checkbox"/> Permanent total disability | <input type="checkbox"/> Attorney fees |
| <input type="checkbox"/> Permanent partial disability | <input type="checkbox"/> Disfigurement |
| <input type="checkbox"/> Safety device increase (name device): _____ | |
| <input type="checkbox"/> Mental impairment: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary | |
| <input type="checkbox"/> Medical benefits (list here or attach unpaid bills): _____ | |
| <input type="checkbox"/> Determination of: <input type="checkbox"/> Bad Faith/Unfair Claims Processing <input type="checkbox"/> Fraud or <input type="checkbox"/> Retaliation | |
| <input type="checkbox"/> Other (specify): _____ | |

12. Complaints by Employer:

- | |
|---|
| <input type="checkbox"/> Determination of compensability/benefits |
| <input type="checkbox"/> Safety device decrease (name device): _____ |
| <input type="checkbox"/> Reimbursement right |
| <input type="checkbox"/> Credit for overpayment |
| <input type="checkbox"/> Suspension or reduction of benefits (state grounds): _____ |
| <input type="checkbox"/> Other (specify): _____ |

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

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

If yes, what language? _____
(Employer will pay for cost of interpreter)

15. WCA Field Office needed for Mediation? ☐ Yes ☐ No (If yes, please check all that apply)

☐ Farmington ☐ Hobbs ☐ Las Cruces ☐ Las Vegas ☐ Roswell ☐ Santa Fe

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 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
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).

<input type="checkbox"/> Treatment for alcohol and/or substance abuse	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> HIV or AIDS
<input type="checkbox"/> Behavioral or Mental Health, including Psychiatric or Psychological	<input type="checkbox"/> 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 NOTIFYING 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

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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
WCA-UEF@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