

**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](mailto:WCA-UEF@state.nm.us)





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 (\$.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 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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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](mailto: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**