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 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 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

    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:

    ☐ Temporary total disability
    ☐ Death benefits
    ☐ Permanent total disability
    ☐ Attorney fees
    ☐ Permanent partial disability
    ☐ 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):

12. 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):

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

14. Is an interpreter needed for the 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 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 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.