NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION OUT OF STATE HEALTH CARE PROVIDER AFFIDAVIT

1. I, being duly sworn or affirmed, state: I am licensed as a ______, in the State of ______, and my license to practice is currently in good standing;

2. I acknowledge that I have treated or intend to treat injured worker

_____(name) involved in a workers' compensation claim governed by the laws of New Mexico;

3. I agree to be bound by the Workers' Compensation Act of the State of New Mexico and all Workers' Compensation Administration (WCA) rules and regulations, including the WCA Health Care Provider Fee Schedule unless I have separately negotiated fees with the payer prior to rendering services; and

4. I understand that if my license to practice in ______ is suspended or revoked, my designation as an approved health care provider is automatically revoked.

Signature

Health Care Provider – Printed Name

Address

City/State/Zip

Telephone

ACKNOWLEDGMENT

STATE OF ________) ss. COUNTY OF ________) Subscribed and sworn or affirmed to before me this _____ day of ______, 20_____.

My commission expires:

Rev. 12/22 11.4.7.10 NMAC Notary Public