**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 No.: (___) ____________________
3. Worker's date of birth: _____/_____/_____ Age: ____ Sex: ____M ____F
4. Worker's Social Security Number: _______-______-_______
5. Full Name of Employer: ____________________
   Employer's Address: ____________________
   City/State/Zip: ____________________
   Telephone No.: (___) ____________________
6. Insurance Carrier: ____________________
   Address: ____________________
   City/State/Zip: ____________________
   Telephone No.: (___) ____________________
7. Date of Accident: ____________________
   a. City and County of accident: ____________________
   b. Worker's job at time of accident: ____________________
   c. Worker's average weekly wage: ____________________
   d. Weekly compensation rate: ____________________
   e. How did the accident occur: ____________________
   f. Nature of the injury: ____________________
   g. Part(s) of the body injured: ____________________
   h. Name and address of treating Doctor(s):____________________
   i. First date Worker was unable to perform job duties: ____________________
   j. Date of maximum medical improvement: ____________________
   k. Impairment rating: ____________________Date assessed: ____________________
      Doctor's Name: ____________________
   l. Has Worker been released to work by a Doctor? ___ Yes ___ No [check one]
      If yes, please indicate the date Worker was released to work:____________________
   m. Has Worker returned to work since the accident? ___Yes ___ No [check one]
      If yes, please indicate the date Worker returned to work: ____________________
   n. Name and address of current Employer: ____________________
      ____________________
   o. Highest level of school completed by Worker: ____________________
8. a. What benefit or relief is being sought?
      1. Complaints 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):________________________________________________________

2. 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):____________________________________________________________

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

9. Is an interpreter needed for the hearings on this complaint? ___Yes ___ No.
If yes, what language? _____________________________. If yes, Employer must furnish.
If you have questions, call 1-800-255-7965, Mediation Bureau.

10. Medicare Eligibility:
a. Is Worker a current Medicare beneficiary? ___ Yes ___ No
b. Has Worker applied for Social Security Disability benefits in the past 5 years? ___ Yes___ No
c. Has Worker been diagnosed with End Stage Renal Disease? ___ Yes ___ No
(*See* 42 USC 426-1)

| | |
|---|---|
| ____________________________ | ____________________________ |
| Worker's Signature | Attorney's Signature |
| ____________________________ | ____________________________ |
| Date | Worker/Attorney's Name |
| | ____________________________ |
| | Worker/Attorney's Address |
| | ____________________________ |
| | Worker/Attorney's City, State, Zip |
| | ____________________________ |
| | Worker/Attorney's Telephone & Fax Number |

A Summons for each adverse party and insurer shall be filed with the Complaint. If the Worker is filing this Complaint, an Authorization to Release Medical Information form shall be filed with the Complaint.

**STATE OF NEW MEXICO**

**WORKERS' COMPENSATION ADMINISTRATION**

________________________________________, WCA No.:____________________

Worker,

v.

________________________________________, and

________________________________________,

Employer/Insurer.

**SUMMONS FOR WORKERS' COMPENSATION COMPLAINT**

TO: ________________________________________ ________________________________________

________________________________________ ________________________________________

________________________________________ ________________________________________

GREETINGS:

You are directed to serve a written response to the Workers' Compensation Complaint **not less than five (5) days prior to the mediation conference**, and file the same, as provided by law.

You are notified that, unless you serve and file a responsive pleading or motion, 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**

(SEAL)

By:________________________________________________

Date:______________________________________________

**(EACH ADVERSE PARTY MUST BE NAMED IN THE SUMMONS)**

**WORKER'S AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)**

I, (Print Worker's Name) ____________________________________________________, hereby authorize the health care provider (HCP) – (the name of HCP is optional and not required for release of medical information) (Print Health Care Provider's Name) ________________________________________ the use or disclosure of my health information as described in this authorization.

1. **INFORMATION** WCA No. ______________________

Date of Birth _________________ Date of Injury _________________ SSN ______________________

Address ________________________________________________ Phone ______________________

Worker's representative, if any: ______________________________ Phone ______________________

Address: ___________________________________________________________________________

2. **RELEASE**

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, ____________________________________________________, and/or its insurance carrier, ____________________________________________, and/or their attorneys, and/or duly authorized representatives of the New Mexico Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me or my representative as listed above.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This release may also be used to request a Form Letter to HCP as approved by the Workers' Compensation Administration. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

**CONDITIONS**

4. I understand the purpose of this request is to determine the proper level of workers' compensation benefits and may include information regarding any of the following: to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that after this information is disclosed, the recipient may continue to use it pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization ☐ Yes ☐ No - If Yes, I have received a copy _______ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

**Signature of Employee** ____________________________________________ Date ___________________________

**Personal Representative Section:**

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): ____________________________________________
___________________________________________________________________________________________________.

**Signature of Personal Representative** _________________________________ Date __________________________