

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.: _____
Worker,
v. _____, and
_____,
Employer/Insurer.

HEALTH CARE PROVIDER DISAGREEMENT FORM

OBJECTION TO NOTICE OF CHANGE

The Notice of Change was completed by: ____ Worker ____ Employer on the _____, 20___. The Notice of Change is objected to by the ____ Worker ____ Employer. A health care provider hearing is requested on this Objection to Notice of Change because: _____

Signature of filing party

- | | |
|---|---|
| 1. Worker's Name: _____
SSN: _____
Date of Accident: _____
Mailing Address: _____
City/State/Zip: _____
Phone Number: (____) _____ | 2. Worker's Rep: _____
Address: _____
City/State/Zip: _____
Phone Number: (____) _____
Fax Number: (____) _____ |
| 3. Employer: _____
Address: _____
City/State/Zip: _____
Phone Number: (____) _____
Fax Number: (____) _____ | 4. Insurer: _____
Address: _____
City/State/Zip: _____
Phone Number: (____) _____
Fax Number: (____) _____ |
| 5. Employer's Rep.: _____
Address: _____
City/State/Zip: _____
Phone Number: (____) _____
Fax Number: (____) _____ | |

[This form must be filed with the Clerk of the Workers' Compensation Administration]