



Workers' Compensation Administration

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GUIDE

To Completing and Filing
Paper Copy For:

**EMPLOYER'S FIRST REPORT
OF INJURY OR ILLNESS**
Form (E1.2)

NOTICE OF BENEFIT PAYMENT
Form (E6.2)



Phone Numbers

Farmington 599-9746/1-800-568-7310
Las Cruces 524-6246/1-800-870-6826
Las Vegas 454-9251/1-800-281-7889
Lovington 396-3437/1-800-934-2450

E3 Booklet
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INTRODUCTION TO THE E1.2

This guide has been compiled for the use of employers and employers' representatives in completing the Employer's First Report of Injury or Illness (E1.2). This guide explains the purpose of the Employer's First Report of Injury or Illness and provides instructions on how to complete the form. For information on EDI, or questions concerning the reporting requirements, please contact the Economic Research Bureau of the New Mexico Workers' Compensation Administration (WCA). See Appendix for a copy of form E1.2.

BUSINESS PURPOSE

The information collected on the E1.2 is used by the WCA to determine which workers are more at risk on injuries or illnesses, the types of accidents and the natures, sources and parts of body of the injury or illness. This injury information in conjunction with the cost data collected from the Notice of Benefit Payment provides injury trend information. This information assists policy makers, employers and the public to determine methods for improving the workers' compensation system. It is also used to improve safety for New Mexico workers.

The Employer's First Report of Injury or Illness has the following uses:

- ◆ To report all alleged work-related injuries or illnesses resulting in more than seven days of lost time or the death of the worker;
- ◆ To provide data without the employer's admission or denial as to whether the worker's alleged injury or illness is compensable;
- ◆ To provide an equivalent to OSHA form 301 so that the employer can complete just one form on an accident; and
- ◆ To monitor the rate of work-related injuries and illnesses.

GENERAL EMPLOYER REQUIREMENTS

Insurance Coverage: See *The Workers' Compensation Handbook for New Mexico*, Booklet A, "Workers' Compensation Insurance Coverage" (Available from any office of the WCA).

Workers' Compensation Act Poster and Notice of Accident Forms: The Workers' Compensation Act Poster and Notices of Accident forms are required to be posted in a conspicuous place at the job site. Any WCA poster issued since 1991 satisfies the legal requirements. If these have not been provided by your insurance carrier or Third Party Administrator, they may be obtained from the WCA.

What To Do After An Accident: See Booklet B1 of the Handbook by that title for information on completion of the Notice of Accident form. For information regarding health care providers see Booklet B4 ("Health Care Issues in Workers' Compensation"). The worker must also be furnished with the name of the insurance carrier. Tips for facilitating the worker's return to work are included in Handbook Booklets B2 ("Benefits for Long-term or Serious Injuries") and B3 ("Going Back to Work").

FILING THE EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

Who Files: This form must be completed by the employer or the employer's representative (Claims Administrators can be Third Party Administrators, Insurance Carriers and Self-Insured Employers).

When Required: This form must be filed with the WCA within 10 days of knowledge of any alleged work related injury or illness that results in more than seven days of lost work time or the death of the worker. (The days may be counted as one consecutive week of lost time or as more than seven nonconsecutive days.) The form E1.2 must be completed and submitted even if the employer disputes the compensability of the injury or illness. The E1.2 is not an admission of liability.

Where to File: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at P. O. Box 27198, Albuquerque, NM 87125-7198. Facsimiles of the E1.2 are not accepted by the WCA due to the lack of quality.

Copies must also be provided to the worker and the employer's workers' compensation insurer. You may have an agreement with your claims administrator that the administrator will file the original E1.2 with the WCA and insurance carrier for you.

Additional Questions: The Ombudsman Bureau of the WCA is available to assist workers and employers by providing answers to questions about rights or responsibilities under the Act. Ombudsmen are on staff at all WCA offices, at the telephone numbers listed on the cover of this guide, between 8:00 a.m. and 5:00 p.m., business days, Monday through Friday. Questions about an E1.2 may be directed to the Economic Research Bureau.

Penalties: Failure to file, late filing or incomplete filing of the E1.2 may result in a fine on the employer or his claims administrator of up to \$1,000 per occurrence.

COMPLETING THE E1.2 (Employers First Report of Injury or Illness)

The E1.2 form was developed by representatives of several states and other jurisdictions, to provide carriers with a single standard report form. This form is in use in several states, but since state laws differ, the information required by each state also varies. The blocks of information required on the form are defined in **RED**. Blocks defined in **BLUE** are also required if known at the time. The shaded blocks may be used at the option of the employer or carrier.

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1.2 may be returned to the sender. Facsimiles of the E1.2 are not accepted by the WCA.

DEFINITIONS

Each data item on the E1.2 form is defined within and assigned to one of the following four categories: "Mandatory", "Required", "Optional", or "Not Required".

- **Mandatory** data items are defined in red. The employer and/or employer representative must complete the information on this data item.

- **Required** data elements are defined in blue and must be completed if the information is known at the time of filing. If the information becomes available at a later date a follow-up report showing the change should be sent to the WCA.
- **Optional** data elements defined in black may be used by the employer for their benefit. If provided, these elements may be used by the WCA Economic Research Bureau.
- **Not Required** data elements do not need to be provided. If provided, these elements are not used by the WCA Economic Research Bureau.

GENERAL DATA BLOCK

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE
	1		4		5
			JURISDICTION	JURISDICTION CLAIM NUMBER	
			6	7	
			INSURED REPORT NUMBER		
		8			
PHONE NUMBER		EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #	INDUSTRY CODE
10		3	9		2

1. **Employer:** The name and mailing address (including Zip Code) of the business entity employing or legally responsible for the injured or ill worker. (Mandatory)
2. **Industry Code:** Represents the nature of the employer's business at the location where the worker was employed at the time of the injury or illness exposure. It is found in the *North American Industrial classification system* Manual, published by the Federal Office of Management and Budget. (Required, if known) (Mandatory on all disability claims) See page 31 for *North American Industrial classification system* manual information.
3. **Employer FEIN:** Employer's Federal Identification Number, assigned by the Internal Revenue Service. (Mandatory)
4. **Carrier/Administrator Claim Number:** The identification claim number assigned by the carrier or claims administrator. (Required, if known)
5. **Report Purpose Code:** Identifies why the report is being filed with the WCA. (Required, if known) The following codes may be used:

00:	The report being sent is the initial First Report of Injury or Illness
02:	Indicates that the report being sent is a follow-up report showing a change of information on the First Report of Injury or Illness. An initial First Report must have previously been sent to the WCA.

6. **Jurisdiction:** The jurisdiction / state under whose laws this claim will be resolved. (Not Required)
7. **Jurisdiction Claim Number:** The number assigned by the jurisdiction or state at the time of benefits being paid to the worker or for a complaint being filed with the Clerk's Office. (Not Required)
8. **Insured Report Number:** The claim number assigned by the employer. (Optional)
9. **Location #:** A number assigned by the employer to identify the location of the accident. (Optional)
10. **Employer's Location Address (If Different):** The address of the employer's facility where the worker was employed at the time of the injury or illness. (Mandatory, if different from the employer's mailing address)
11. **Phone #:** Telephone number at the employer's location. Include area code if the employer's location is outside New Mexico. (Required, if known)

CARRIER/CLAIMS ADMINISTRATOR DATA BLOCK

C A R R I E R C L A I M S A D M I N I S T R A T O R	CARRIER (NAME, ADDRESS & PHONE NO) 1		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) 6		
	CARRIER FEIN 2		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE 4		ADMINISTRATOR FEIN 7	
	AGENT NAME & CODE NUMBER 8		POLICY / SELF-INSURED NUMBER 5			

- Carrier:** Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the injured worker's employer. A self-insured employer should enter its business name. If not in New Mexico, include telephone number with area code. (Mandatory)
- Carrier FEIN:** Carrier's Federal Identification Number, assigned by the Internal Revenue Service. (Mandatory)
- Policy Period:** The effective dates of the policy purchased by the insured employer. (Not Required)
- Self-Insurance:** Check the Self-Insurance box if the employer is under an individual or group self-insurance program approved by the WCA. (Mandatory)
- Policy/Self-Insurance Number:** (Not Required)
- Claims Administrator:** Name, mailing address and phone number of the carrier, third party administrator, or self-insured processing the claim (Mandatory)
- Administrator FEIN:** The Claims Administrator's Federal Identification Number, assigned by the Internal Revenue Service. (Mandatory)
- Agent Name & Code Number:** (Not Required)

EMPLOYEE DATA BLOCK

E M P L O Y E E	NAME (LAST, FIRST, MIDDLE) 1		DATE OF BIRTH 4	SOCIAL SECURITY NUMBER 5	DATE HIRED 6	STATE OF HIRE 7	
	ADDRESS (INCL ZIP) 2		GENDER <input type="checkbox"/> MALE 8 <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED 9 <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE OR (SOC) CODE 10		EMPLOYMENT STATUS 12
	PHONE NUMBER 3		# OF DEPENDENTS 11			NCCI CLASS CODE 13	

- Name:** Injured worker's last name, first name and middle initial or middle name. (Mandatory)
- Address:** Injured worker's mailing address, including the zip code. (Mandatory)
- Phone:** Injured worker's telephone number. (Required, if known)
- Date of Birth:** Injured worker's birth date. (Mandatory)
- Social Security Number:** Injured worker's SSN (Mandatory)
- Date Hired:** The date the injured worker began employment with this employer. If there have been multiple periods of employment, enter the beginning date of the current period. (Mandatory)
- State of Hire:** The condition of employment (i.e., Part Time, Full Time, Volunteer) of the injured worker with the employer at the time of the accident or illness.(Optional)

8. **Gender:** The gender of the injured worker at the time of the accident. (Mandatory)
9. **Marital Status:** Self-explanatory. (Mandatory)
10. **Occupation/Job Title:** The worker's occupation at the time of the accident or illness. Use the Standard Occupational Titles in the *SOC manual*, printed by the National Technical Information Service (1.800.553.6847) or on the web at <http://stats.bls.gov/soc/> and select soc users guide. (Mandatory) See page 31 for manual information.
11. **Number of Dependents:** Self-explanatory. (Mandatory)
12. **Employment Status:** A code used to indicate the employee's primary work status at the time of the injury with the covered employer: PW = Piece Worker, SL = Seasonal Worker, FT = Full Time, PT = Part Time, NE = Not Employed, OS = On Strike, AF = Apprenticeship Part Time, UK = Unknown, RT = Retired, DS = Disabled. (Optional)
13. **NCCI Class Code:** Corresponds to the primary occupation in which the claimant was engaged at the time of the accident or illness. (Optional)

WAGE DATA BLOCK

3

W A G E	RATE PER: 1	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK 2	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? 4 <input type="checkbox"/> YES <input type="checkbox"/> NO
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1. **Rate:** The amount of the pre-injury wage in dollars and cents. Please check the appropriate wage period. (Mandatory)
2. **# Days Worked/Week:** The number of the worker's regularly scheduled work days per week. (Optional)
3. **Full Pay for Day of Injury?:** Indicates whether full wages for the date of accident or illness were paid to the injured worker by the employer. (Mandatory)
4. **Did Salary Continue?:** Indicates whether the employer is continuing to pay the worker's regular wages without charge to employee benefits (vacation time, sick days, etc.) during an absence due to the injury. This indicator is used if an injured worker is being paid his regular salary under an "injury time" program established by the employer. Note: The wage paid under a program of this type is not considered workers' compensation and is a special benefit paid by the employer. (Mandatory)

OCCURRENCE DATA BLOCK

O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK 1	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS 2	TIME OF OCCURRENCE 3	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE 4	DATE EMPLOYER NOTIFIED 5	DATE DISABILITY BEGAN 6	
	CONTACT NAME / PHONE NUMBER 7			TYPE OF INJURY/ILLNESS 8			PART OF BODY AFFECTED 9		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? 10 <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY / ILLNESS CODE 11			PART OF BODY AFFECTED CODE		
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED 12				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED 13				
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED 14				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED 15				
	HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL. 16								CAUSE OF INJURY CODE 17
	DATE RETURNED TO WORK 18		IF FATAL, GIVE DATE OF DEATH 19		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? 20			<input type="checkbox"/> YES <input type="checkbox"/> NO	
					WERE THEY USED? 21			<input type="checkbox"/> YES <input type="checkbox"/> NO	

1. **Time Employee Began Work:** The time the employee began work the date of the injury. (Optional)
2. **Date of Injury/Illness:** For a traumatic injury (injury resulting from a single accident), enter the date of occurrence. In the case of an occupational illness, (arising from the workers' activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related, whichever is earlier. This item is very important because it is used along with SSN for identification and computer tracking of the First Report information. (Mandatory)
3. **Time of Occurrence:** For a traumatic injury, enter the time at which the accident occurred. Otherwise, leave blank. (Optional)
4. **Last Work Date:** The last date the employee actually worked. Do not add days for which the employee was absent from work in a paid status (vacation, comp time, sick days, etc.) (Required, if known)
5. **Date Employer Notified:** The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness. (Mandatory)
6. **Date Disability Began:** The first full day on which the worker lost time from work due to the injury or illness. (Required, if known)
7. **Contact Name/Phone Number:** Name and telephone number of the individual at the employer's premises to be contacted for additional information. Include area code if not in New Mexico. (Required)
8. **Type of Injury or Illness:** Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible. (Mandatory)
9. **Part of Body Affected:** The specific part of body affected by the injury or illness (for example: right knee, lower back). (Mandatory)
10. **Did Injury/Illness Occur on Employer's Premises?:** Self-explanatory. (Mandatory)
11. **Type of Injury or Illness Code and Part of Body Code:** (Optional) See Codes in Appendix.
12. **Department or Location:** If applicable, specify department or division where the injured worker is regularly employed. If the accident or illness exposure occurred somewhere other than on the employer's premises, enter specific address or location (for example, Client's office at 123 Main Street, Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP code or County. (Mandatory)
13. **All Equipment, Materials or Chemicals:** List all of the equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example: decorators' scaffolding, electric sander, paintbrush and paint). Enter "NA" if no equipment, materials or chemicals were being used. The items listed do not have to be directly involved in the worker's injury or illness. (Optional)
14. **Specific Activity:** Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example: sanding ceiling woodwork in preparation for painting).
15. **Work Process:** Describe the specific activity the worker was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" if the worker was not engaged in a work process (for example, if the worker was walking along a hallway.) (Mandatory)
16. **How Injury or Illness Occurred:** Describe how the injury or illness occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.) (Mandatory)
17. **Cause of Injury Code:** Optional. (See Codes in the Appendix)

- 18. **Date Returned to Work:** Date the injured worker returned to work under restrictions, part time or full time. Complete this block if the date is known at the time of filing the E1.2. (Required, if available)
- 19. **If Fatal, Give Date of Death:** Self-explanatory. (Required, if available)
- 20. **Were Safeguards or Safety Equipment Provided?:** This refers to safety devices required by law or in general use in the industry. (Mandatory)
- 21. **Were They Used?:** Refers to safety devices in the previous question. (Optional)

TREATMENT DATA BLOCK

T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT	
	1		2	<input type="checkbox"/> NO MEDICAL TREATMENT	3
			<input type="checkbox"/> MINOR: BY EMPLOYER		
			<input type="checkbox"/> MINOR CLINIC/HOSPITAL		
			<input type="checkbox"/> EMERGENCY CARE		

- 1. **Physician/Health Care Provider:** If worker was treated at the office of a physician or other health care provider, enter the identifying information. This includes an urgent care clinic. (Optional)
- 2. **Hospital:** If worker was hospitalized or treated at an emergency room, enter the identifying information. (Optional)
- 3. **Initial Treatment:** Check appropriate box. (Mandatory)

OTHER DATA BLOCK

O T H E R	WITNESSES (NAME & PHONE #)			<input type="checkbox"/> HOSPITALIZED > 24 HRS
	1			<input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	
	2	3	4	

- 1. **Witnesses:** (Not Required)
- 2. **Date Administrator Notified:** The date the claims administrator who is processing the claim received notice of the occurrence. (Mandatory)
- 3. **Date Prepared:** Date this form was prepared. (Optional)
- 4. **Preparer's Name and Title:** This form must be completed by the employer or the employer's representative, not by the injured worker. (Optional)

OSHA REQUIREMENTS

This form, with all unshaded spaces completed, is equivalent to the OSHA form 301 Supplemental Report. You must put in the OSHA log number required by OSHA in the box labeled "OSHA Log Number" in the GENERAL information block.

NOTE: There may be cases where data that are "Not Required" or are considered "Optional" by the WCA are required to be entered on the OSHA log. Contact the New Mexico Occupational Health and Safety Bureau at 827-4230 with any questions.

NOTICE OF BENEFIT PAYMENT FORM (E6.2)

This section of the guide is for the use of self-insured employers, insurance carriers and claims administrators in completing the paper-copy version of the Notice of Benefit Payment (E6.2). This section explains the purpose of the E6.2, the filing requirements, and provides instructions for completing the E6.2. Insurance carrier requirements are also outlined in this section. For questions regarding the E6.2 or for reporting requirements, please contact the Economic Research Bureau of the New Mexico Workers' Compensation Administration (WCA). See Appendix for a copy of the printed E6.2 form.

PURPOSE FOR REPORTING

The information reported on the E6.2 is used by the WCA to monitor costs of claims based on disability payments and medical services provided to injured or ill workers. This information is critically important in assessing the effectiveness of cost containment efforts implemented by the New Mexico Workers' Compensation Act. This information, in conjunction with the injury and illness information from the First Report of Injury or Illness, also enables the administration to evaluate the current status of the worker's compensation system in relation to previous accident years.

The Notice of Benefit Payment is used to report:

- ◆ Payment data on medical only or indemnity claims.
- ◆ Disability payments being made to the injured or ill worker, the date on which initial payments began and the date of compensability.
- ◆ Closing payments of indemnity or medical only claims.
- ◆ Changes in payment due to changes in employment, changes in disability type, and to indicate lump sum distributions

GENERAL REQUIREMENTS

An insurance carrier issuing worker's compensation policies in New Mexico must meet the following requirements:

1. Have a representative with a financial presence in New Mexico.
2. File with NCCI a proof of workers' compensation coverage for each insured.
3. Conduct an annual safety inspection of each insured with an annual premium of more than \$5,000.
4. Report all claims activity for the insured based on these guidelines, including reporting of the first dollar of indemnity claims paid by the employer who has a deductible policy.

Insurance carriers, claim administrators and self-insured employees must also abide by the Workers' Compensation Act and regulations. Carriers and claim administrators are additionally subject to guidelines set out by the New Mexico Superintendent of Insurance. Questions about insurance status may be directed to the Workers' Compensation Administration's Employer Compliance Bureau at (505) 841-6050.

FILING THE E6.2

WHO FILES: This form should be completed by the claims administrator who makes any indemnity claim or multiple visit medical claim payments for an employer or the employer's representative.

WHEN TO FILE:

This form must be filed within 10 days of the date of the initial indemnity or 90 days for medical only payments. When reporting a change in benefit payments, this form must be filed within 30 days of the change. In the case of a closing payment, this form must be filed within 30 days of the final payment.

WHERE TO FILE:

Mail the original E6.2 to the New Mexico WCA (Attention: Economic Research Bureau) at the address on the back of the form.

QUESTIONS: Questions may be directed to the Economic Research Bureau at 505-841-6000, or toll-free in New Mexico at 1-800-255-7965.

CHANGES IN THE E6.2 FORM

Several improvements have been made to the E6.2 form to clarify data requirements and to bring the hard copy reporting closer to the Electronic Data Interchange (EDI) standards established by the International Association of Industrial Accident Boards and Commissions (IAIABC).

COMPLETING THE E6.2: WHAT TO FILL OUT WHEN

TABLE 1 Mandatory Information Requirement for E6.2 Indemnity Claims						
Report Type	Purpose Block	Carrier Block	Employer Block	Employee Block	Occurrence Block	Benefit Payment Block
All Indemnity Claims <i>All Blocks Indicated must be completed.</i>	<ul style="list-style-type: none"> Date of Payment/action 	<ul style="list-style-type: none"> Name/Address FEIN Clm admin/name & address FEIN 	<ul style="list-style-type: none"> Name / Address FEIN 	<ul style="list-style-type: none"> Name, Address SSN 	<ul style="list-style-type: none"> Date of the Injury/Illness Date of Death (If death occurred) 	<ul style="list-style-type: none"> Initial Payment type Paid to date all benefits # of weeks # of days Lump Sum Amts
Initial Indemnity Payment	<ul style="list-style-type: none"> Report Purpose: IP Claim Type: I Claim Status: O 		<ul style="list-style-type: none"> NAICS Type of Business 	<ul style="list-style-type: none"> # of Children Avg. Weekly Wage 	<ul style="list-style-type: none"> Describe the Accident Date of Disability (1st & 8th) 	
Became Indemnity Claim	<ul style="list-style-type: none"> Report Purpose: IP Claim Type: L Claim Status: O, R 		<ul style="list-style-type: none"> NAICS Type of Business 	<ul style="list-style-type: none"> # of Children Avg. Weekly Wage 	<ul style="list-style-type: none"> Describe the Accident Date of Disability (1st & 8th) 	<ul style="list-style-type: none"> Change in payment type
Change in Benefit Payment	<ul style="list-style-type: none"> Report Purpose: CB Claim Type: I Claim Status: O 				<ul style="list-style-type: none"> Date of MMI (if PPD) 	
Closing Payment	<ul style="list-style-type: none"> Report Purpose: FN Claim Type: I Claim Status: C, X 				<ul style="list-style-type: none"> Date of release\ returned to work Restrictions 	

• Indicates the Data Block should be completed based on reporting
Reporting Purpose: IP = Initial Payment, CB = Change in Benefit Payment, FN = Closing Payment
Claim Type: I = Indemnity, L = Became Indemnity, M = Medical Only
Claim Status: O = Open, R = Reopened, C = Closed, X = Reopened / Closed

Table 1 shows how indemnity claims should be reported and Table 2 shows how medical only claims would be reported to the WCA using the E6.2 form. Tables 1 and 2 also define how to complete the E6.2 PURPOSE BLOCK by reporting type. For each report type indicated by the left-most column, mandatory data fields are identified for each of the blocks on the E6.2 form. For example, a claims administrator sending an E6.2 form for an initial payment on an indemnity claim would complete the information in the row labeled “Initial Payment” as well as the information in the “All Indemnity Claims” row. (See table 1) (Note: All mandatory fields have been highlighted in RED on the E6.2 form.)

TABLE 2 Mandatory Information Requirement for E6.2 Medical-Only Claims						
Report Type	Purpose Block	Carrier Block	Employer Block	Employee Block	Occurrence Block	Benefit Payment Block
All Med-Only Claims (E6.2) <i>All Blocks Indicated must be completed.</i>	<ul style="list-style-type: none"> Date of Payment/action 	<ul style="list-style-type: none"> Name/Address FEIN Clm admin/name & address FEIN 	<ul style="list-style-type: none"> Name / Address FEIN 	<ul style="list-style-type: none"> Name, Address SSN 	<ul style="list-style-type: none"> Date of the Injury/Illness Date of Death (If death occurred) 	<ul style="list-style-type: none"> Initial Payment type Paid to date medical benefits
Initial Payment (E1.2 has been filed with the WCA)	<ul style="list-style-type: none"> Report Purpose: IP Claim Type: M Claim Status: O 		<ul style="list-style-type: none"> NAICS Type of Business 	<ul style="list-style-type: none"> # of Children Avg. Weekly Wage 	<ul style="list-style-type: none"> Describe the Accident Date of Disability (1st & 8th) Date Rtn to Work 	
Initial Payment (E1.2 has been filed with the WCA)	<ul style="list-style-type: none"> Report Purpose: IP Claim Type: M Claim Status: O 	<ul style="list-style-type: none"> Phone #'s 	<ul style="list-style-type: none"> NAICS Type of Business 	<ul style="list-style-type: none"> # of Children Avg. Weekly Wage Date of Birth Date of Hire Gender Marital Status Occupation 	<ul style="list-style-type: none"> Describe the Accident Date of Disability (1st & 8th) Pre-existing disability Date Rtn to Work 	
Closing Payment	<ul style="list-style-type: none"> Report Purpose: FN Claim Type: M Claim Status: C, X 					

EXAMPLE:

This means that for an initial payment, the claims administrator would complete the following data items on the E6.2 for the indemnity claim:

STEPS:

- 1) Place a check mark in the box indicating Initial Payment (IP) for the *Reporting Purpose*, and give the date of the payment. Put a check mark for Indemnity in the *Claim Type* box, and place a check mark in the Open box for the *Current Claims Status*.
- 2) Complete the entire **CARRIER BLOCK** of information.
- 3) Complete the entire **EMPLOYER BLOCK** of information.
- 4) Complete the *Name, Address, and Social Security Number (SSN)* of the injured worker. Also, include the *Number of Children* and the *Average Weekly Wage*. (Note: for an indemnity claim, an E1.2 has been filed with the WCA prior to the initial payment.)
- 5) Complete the *Date of Injury or Death Date*, describe the accident, and give the disability date (first day) and compensability date (eighth day).
- 6) Complete the **BENEFIT PAYMENTS BLOCK** of information.

A flowchart has been included in the APPENDIX to help clarify the sequence of filing requirements relating to the E1 and E6.

NOTE: Please print in black ink or type, and ensure that all entries are legible. An illegible or incomplete E6.2 may be returned to the sender.

DEFINITIONS

Each data item on the E6.2 form is defined within and assigned to one of the following four categories: “Mandatory”, “Required”, “Optional”, or “Not Required”.

- **Mandatory** data items are defined in red. The employer and/or employer representative must complete the information on this data item.
- **Required** data elements are defined in blue and must be completed if the information is known at the time of filing. If the information becomes available at a later date a follow-up report showing the change should be sent to the WCA.
- **Optional** data elements defined in black may be used by the employer for their benefit. If provided, these elements may be used by the WCA Economic Research Bureau.
- **Not Required** data elements do not need to be provided. If provided, these elements are not used by the WCA Economic Research Bureau.

PURPOSE BLOCK

P U R P O S E	REPORTING PURPOSE	DATE OF PAYMENT / ACTION	CLAIM ADMINISTRATOR CLAIM NO. 5	
	<input type="checkbox"/> INITIAL PAYMENT <input type="checkbox"/> CHANGE IN PAYMENT <input type="checkbox"/> CLOSING PAYMENT <input type="checkbox"/> REOPENED <input type="checkbox"/> CORRECTION	1 _____	2 _____	CURRENT CLAIM TYPE <input type="checkbox"/> MEDICAL ONLY <input type="checkbox"/> INDEMNITY 3 <input type="checkbox"/> BECAME INDEMNITY <input type="checkbox"/> OTHER

- Reporting Purpose** (Mandatory) This identifies the purpose of the report. Five possible reporting options are designated on the E6.2 form: Initial Payment of Benefits (Medical or Indemnity) – Change in Benefit Payment (i.e., indemnity benefits changing due to disability status) – Closing Payment of Benefits (i.e., final indemnity payment to injured worker) – Reopened – and Correction (i.e., a change on information that was sent on a previous report).
- Date of Payment/Action** (Mandatory) This is the date that the initial payment, change in benefits, or closing payment was made on behalf of the injured or ill worker.
- Current Claim Type** (Mandatory) This identifies type of claim reported. A claim is identified as indemnity when any disability benefits are paid to the injured or ill worker during the lifetime of the claim. A medical-only claim is defined as a claim in which payments of medical services have been paid only during the lifetime of the claim. A claim becomes an indemnity claim when disability payments to the injured worker begin after the claim was initially paid as medical-only. Other is checked when attorney fees are paid in a controverted case in which benefits have been denied or when funeral costs have been made prior to any benefits being paid.
- Current Claim Status** (Mandatory) There are four options for identifying the status of a claim. An open claim is a claim in which the administrator is expecting additional payments for indemnity or medical benefits within a calendar year period. A closed claim indicates that no additional action on a claim is anticipated and a final medical or indemnity payment has been made. A reopened claim is identified as a claim in which payment has restarted for a claim previously defined as closed and additional payments are expected within the calendar year. A reopened/closed claim occurs when payment has restarted for a claim previously identified as closed and not additional payments are expected within the calendar year.
- Claims Administrator Claims Number** (Mandatory) The number assigned by the claims administrator to uniquely identify the workers' compensation claim.

CARRIER BLOCK

C A R R I E R	CARRIER (NAME & ADDRESS) 1		CLAIM ADMINISTRATOR (NAME & ADDRESS) 4	
	PHONE # 2	CARRIER FEIN 3	PHONE # 5	ADM IN FEIN 6

- Insurance Carrier** (Mandatory) The name and mailing address of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the injured worker's employer. Self-insured employers should enter their business name here.
- Phone Number** (Optional) The carrier's or self-insured's phone number, including the area code if outside N.M.
- Carrier FEIN** (Mandatory) The carrier's or self-insured's Federal Identification Number assigned by the Internal Revenue Service.
- Claims Administrator** (Mandatory) The name, mailing address, and telephone number of the insurance carrier, third party administrator or self-insured responsible for adjusting the claim.
- Claims Administrator Phone Number** (Mandatory)
- Administrator FEIN** (Mandatory) The claims administrator's Federal Employer Identification Number assigned by the Internal Revenue Service.

EMPLOYER BLOCK

EMPLOYER	EMPLOYER (NAME, ADDRESS, & PHONE #) 1		EMPLOYER LOCATION ADDRESS (if different from mailing address) 5	
	EMPLOYER FEIN 2	NAICS CODE 3	SIC CODE 3	TYPE OF BUSINESS 4

- Employer (Name, Address & Phone #)** (Mandatory) Complete the name of the business entity employing the injured or ill worker. Also enter the mailing address including the zip code and phone number.
- Employer FEIN** (Mandatory) The employer's Federal Identification Number, assigned by the Internal Revenue Service.
- Industry Code** (Mandatory for Initial Payment and Became Indemnity reports) The nature of the employer's business as identified by the *North American Industrial Classification System* published by the Federal Office of Management and Budget. (See page 31 for Manual information)
- Type of Business** (Required for Initial Payment and Became Indemnity reports) Specific description of goods and services produced or sold by employer.
- Employer's Location Address** (Required) The address of the employer's facility where the worker was at the time of the injury, if different from mailing address.

EMPLOYEE BLOCK

EMPLOYEE	EMPLOYEE NAME (LAST 1 FIRST MI)		DATE OF BIRTH 3	SOCIAL SECURITY NUMBER 4	DATE HIRED 5
	ADDRESS (INCLUDE ZIP)		GENDER 6 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS 7 U - UNMARRIED S - SINGLE/DIVORCED M - MARRIED P - SEPARATED K - UNKNOWN	OCCUPATION/JOB TITLE 9
	PHONE # 2	# OF CHILDREN 8	AVERAGE WEEKLY WAGE 10		

- Employee** (Mandatory) The name of the injured or ill worker and address of worker's place of residence.
- Employee Phone #** (Optional) The phone number of the injured or ill worker.
- Employee Date of Birth** (Mandatory) The date of birth of the injured or ill worker.
- Social Security Number** (Mandatory) The Social Security Number of the injured or ill worker.
- Date Hired** (Mandatory) The date the injured or ill worker began the employment period for which the report is being filed.
- Gender** (Mandatory) The gender of the injured or ill worker.
- Marital Status** (Mandatory) The marital status of the injured or ill worker.
- Number of Children** (Required for Initial Payment and Became Indemnity reports) The number of worker's dependent children.
- Occupation/Job Title** (Mandatory) The job title of the worker at the time the accident occurred. (Use the *Standard Occupational Classification* manual by the US Dept. of Commerce) (See page 31 for additional information)
- Average Weekly Wage** (Mandatory for Initial Payment and Became Indemnity reports) The weekly wage that was used to calculate worker's benefits.

OCCURRENCE BLOCK

O C C U R R E N C E	DESCRIBE THE ACCIDENT. IDENTIFY HOW THE INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. INCLUDE THE NATURE OF THE INJURY AS WELL AS THE BODY PART AFFECTED.					T OFFICIAL USE	
	1					N	
						B	
						S	
DATE OF INJURY/ILLNESS		IF FATAL, DATE OF DEATH	DATE OF DISABILITY, 1ST DAY		8TH DAY	PRE-EXISTING DISABILITY?	
2		3	4			<input type="checkbox"/> YES 5 <input type="checkbox"/> NO	
DATE OF MAX. MED. IMPROVEMENT		DATE CLAIM ADMIN NOTIFIED	% OF IMPAIRMENT	DATE RELEASED TO WORK	DATE RETURNED TO WK	RESTRICTIONS?	
6		7	8	9	10	<input type="checkbox"/> YES 11 <input type="checkbox"/> NO	

1. **Describe the Accident** (Mandatory for Initial Payment and Became Indemnity reports) Specific description of how the accident occurred as well as the specific activity the worker was engaged in and the sequence of events that led to the accident. Include equipment, materials and chemicals involved. Also be specific as to the nature of the injury and body part affected.
2. **Date of Injury or Illness** (Mandatory) The date of occurrence of injury. For an occupational illness arising from constant exposure to harmful conditions, report the date of diagnosis or the date the illness was first reported to the employer and work-related, whichever is earlier.
3. **If Fatal, Date of Death** (Mandatory) Date on which death occurred as a result of the injury.
4. **Date of Disability** (Mandatory for Initial Payment and Became Indemnity reports) "1st Day" is the date of the worker's first lost time from work due to the injury or illness. "8th Day" is the date on which the worker lost more than seven days of work and became eligible for indemnity benefits. (Mandatory for TTD and PTD claims)
5. **Pre-existing Disability** (Required for Initial Payment and First Report of Injury or Illness has not been filed with the WCA) Identifies the existence of a disability to the same part of body prior to the injury or illness associated with this claim. If unknown, leave blank.
6. **Date of Maximum Medical Improvement** (Required if claim is permanent partial disability) The date on which worker achieved the highest level of recovery from the injury or illness and no further recovery is expected, as determined by the treating physician.
7. **Date Claim Administrator Notified** (Required) The date employer notified the claims administrator of the claim.
8. **Percent of Impairment** (Required if PPD) The degree of functional loss which persists as a result of the injury after the date of maximum medical improvement, as determined by the treating physician.
9. **Date Released to Work** (Mandatory if Closing Payment) The date on which worker is released to return to work, as determined by the treating physician.
10. **Date Returned to Work** (Mandatory if Closing Payment) The date on which worker actually returned to work.
11. **Restrictions** (Required) Identifies limitations to the work activities the worker can perform, as determined by the treating physician.

BENEFIT PAYMENT

INITIAL PAYMENT (CIRCLE ONE) 1 WKLY AMT \$ _____ LATE CODE _____ 3						CHANGE IN PAYMENT (CIRCLE ONE) WKLY AMT \$ _____ 4			
TTD TPD PPD PTD DEATH						TTD TPD PPD PTD DEATH			
BENEFIT PAYMENTS	Category	Paid To Date 2	Weekly Amount	Begin Date	# Weeks	# Days	Lump Sum	Category	Paid To Date
	TTD							Hospital	
	TPD							Physician	
	PPD Scheduled							Therapy	
	PPD Whole Body							Medicine	
	PTD Scheduled							Med. - Other	
	Death							Emplr. - Atty.	
	Unknown							Worker - Atty.	
	Compromise							Legal - Other	
	Voc. Rehab.							Other	
Funeral									
DATE PREPARED 5		PREPARER'S NAME 6				TITLE		PHONE #	

1. **Initial Payment** (Mandatory) For the initial indemnity payment circle only the benefit type and enter the weekly amount of the compensation payment to the injured worker (or beneficiaries). Leave blank for payments other than initial payments. The disability types are:

- ◆ TTD —Temporary Total Disability
- ◆ TPD —Temporary Partial Disability
- ◆ PPD —Permanent Partial Disability
- ◆ PTD —Permanent Total Disability
- ◆ DEATH —Indemnity death benefits paid to survivors. Does not include funeral costs.

2. **Paid to Date** (Mandatory) Enter the total amount of benefits paid to worker to date for each indemnity and medical category. For indemnity benefits, enter amount paid weekly, number of weeks and days paid. Also indicate what total amount was paid as a formal lump sum settlement.

3. **Late Code** (Required) If the initial payment was made more than 14 days after the filing of the First Report of Injury or Illness, enter one of the following codes:

Delays

- L1 – no excuse
- L2 – late notice of loss, employer
- L3 – late notice of loss, employee
- L5 – late notice of loss, doctor
- L7 – late investigation
- L8 – technical processing delay/computer failure insurance agent, or TPA
- L9 – manual processing delay

Errors

- E1 – wrongful determination of no coverage
- E2 – errors from employer
- E3 – errors from employee
- E5 – errors from doctor
- E6 – errors from other claims administrator,

Coverage

C1 – lack of coverage information

Waiting Period

W1 – waiting period completed later than 14th day after filing of E1

Disputes

D1 – dispute concerning coverage

D2 – dispute concerning compensability in whole

D3 – dispute concerning compensability in part

D4 – dispute concerning disability in whole

D5 – dispute concerning disability in part

D6 – dispute concerning impairment

4. **Change in Payment** (Mandatory) If there is a change in type of disability, circle appropriate type and enter new amount. Update all paid to Date Amounts.
5. **Date Prepared** (Required) The date the E6.2 was completed.
6. **Preparer's Name, Title & Phone Number** (Mandatory) Self-explanatory

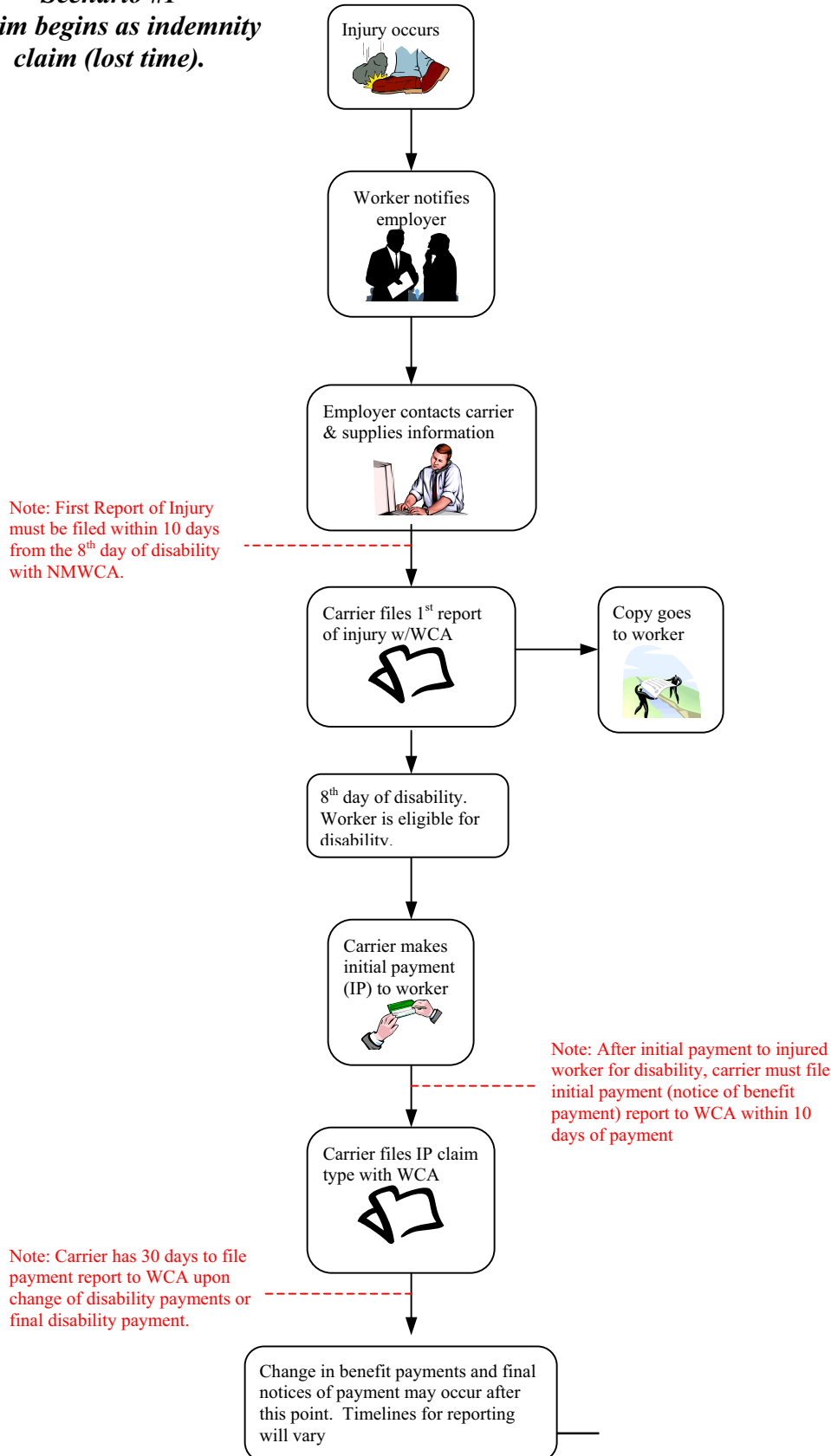
NOTICE:

After completing the E6.2, check that the information in the purpose block is consistent with information in the benefit payment block. For example, a medical only case should not show indemnity payments.

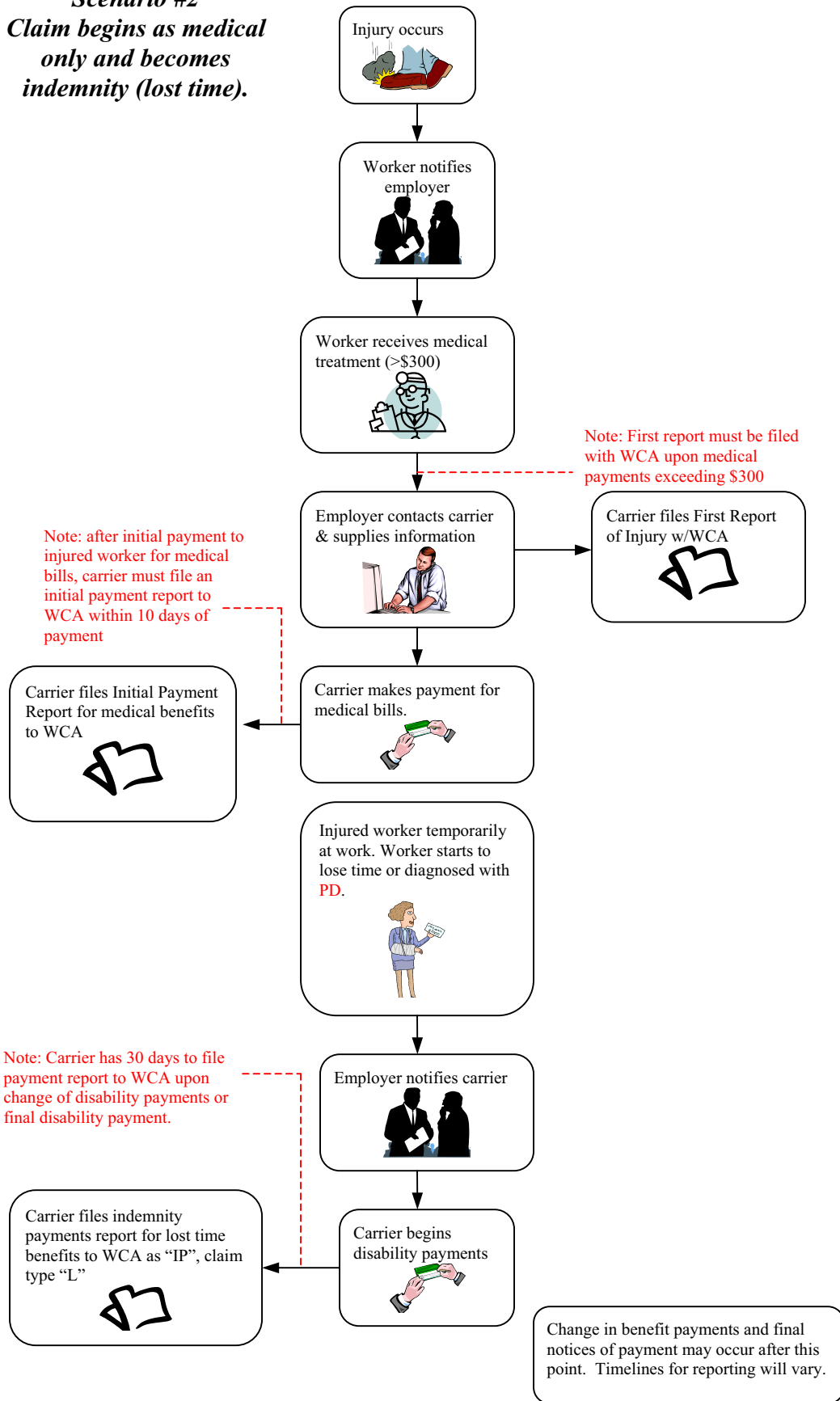
[Use the scenario charts in the Appendix (pages 21, 22, and 23) to determine when to file the appropriate form]

APPENDIX

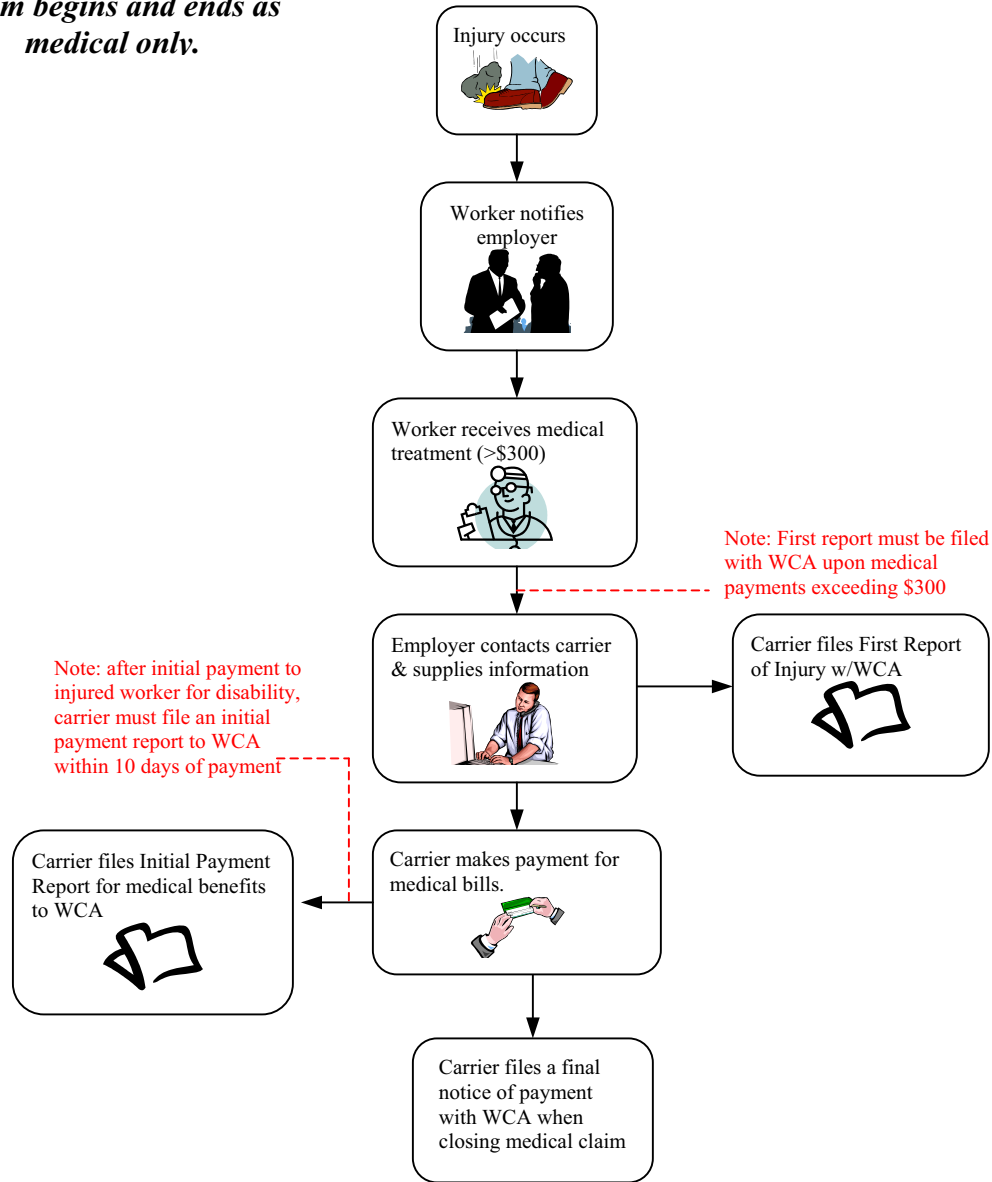
Scenario #1
Claim begins as indemnity
claim (lost time).



Scenario #2
Claim begins as medical
only and becomes
indemnity (lost time).



Scenario #3
Claim begins and ends as
medical only.



CALL FOR DETAILED CLAIM INFORMATION
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Figure A

TABLE 7: PART OF BODY CODES

Code	Part of Body	Code	Part of Body
	I. HEAD		IV. TRUNK
10	Multiple Head Injury	40	Multiple Trunk
11	Skull	41	Upper Back Area (Thoracic Area)
12	Brain	42	Lower Back Area (Inc: Lumbar & Lumbo-Sacral)
13	Ear(s)	43	Disc
14	Eye(s)	44	Chest (Inc: Ribs, Sternum & Soft Tissue)
15	Nose	45	Sacrum & Coccyx
16	Teeth	46	Pelvis
17	Mouth	47	Spinal Cord
18	Other Facial Soft Tissue	48	Internal Organs
19	Facial Bones	49	Heart
	II. NECK		V. LOWER EXTREMITIES
20	Multiple Injury	50	Multiple Lower Extremities
21	Vertebrae	51	Hip
22	Disc	52	Upper Leg
23	Spinal Cord	53	Knee
24	Larynx	54	Lower Leg
25	Soft Tissue	55	Ankle
	III. UPPER EXTREMITIES	56	Foot
30	Multiple Upper Extremities	57	Toe(s)
31	Upper Arm (Inc: Clavicle & Scapula)	58	Great Toe
32	Elbow		VI. MULTIPLE BODY PARTS
33	Lower Arm	60	Lungs
34	Wrist	61	Abdomen (Inc: Groin)
35	Hand	62	Buttocks
36	Finger(s)	63	Lumbar and/or Sacral Vertebrae (NOC Trunk)
37	Thumb	64	Artificial Appliance
38	Shoulder(s)	65	Insufficient Info to Properly ID
39	Wrist and Hands	66	No Physical Injury
		90	Multiple Body Parts
		91	Body Systems & Multiple Body Parts

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Figure B

SECTION 5
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TABLE 8: NATURE OF INJURY CODES

Code	Nature of Injury	Code	Nature of Injury
	I. SPECIFIC INJURY		II. OCCUP. DISEASE OR CUM. INJURY
02	Amputation	60	Dust Disease, NOC (All Other Pneumoconiosis)
03	Angina Pectoris (Assoc. w/Heart Disease)	61	Asbestosis Area (Thoracic Area)
04	Burn	62	Black Lung
07	Concussion	63	Byssinosis
10	Contusion	64	Silicosis (Ribs, Sternum & Soft Tissue)
13	Crushing	65	Respiratory Disorders (Gases, Fumes, Chemicals, etc.)
16	Dislocation	66	Poisoning, Chemical (Other than Metal)
19	Electric Shock	67	Poisoning, Metal
22	Enucleation (Removal of, e.g: Tumor, Eye, etc.)	68	Dermatitis
25	Foreign Body	69	Mental Disorder
28	Fracture	70	Radiation
30	Freezing	71	All Other Occupation Disease Injury, NOC
31	Hearing Loss or Impairment	72	Loss of Hearing
32	Heat Prostration	73	Contagious Disease
34	Hernia	74	Cancer
36	Infection	75	AIDS*
37	Inflammation	76	VDT Related Disease*
40	Laceration	77	Mental Stress
41	Myocardial Infarction (Heart Attack)	78	Carpal Tunnel Syndrome
42	Poisoning, General (Not OD or Cumulative)	80	All Other Cumulative Injuries, NOC
43	Puncture	90	Multiple - Physical Injuries Only
46	Rupture	91	Multiple Injuries, both Physical & Psychological
47	Severance		
49	Sprain		
52	Strain		
53	Syncope		
54	Asphyxiation		
55	Vascular Loss		
58	Vision Loss		
59	All Other Specific Injuries, NOC		

*Effective for claims having accident dates of 1/1/90 and subsequent.

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Figure C

TABLE 9: CAUSE OF INJURY CODES

Code	Cause of Injury	Code	Cause of Injury
I. BURN OR SCALD HEAT OR COLD EXPOSURE		VI. STRAIN OR INJURY BY	
01	Chemicals	52	Continual Noise
02	Hot Objects or Substances	53	Twisting
03	Temperature Extremes	54	Jumping
04	Fire or Flame	55	Holding or Carrying
05	Steam or Hot Fluids	56	Lifting
06	Dust, Gases, Fumes or Vapors	57	Pushing or Pulling
07	Welding Operations	58	Reaching
08	Radiation	59	Using Tool or Machinery
09	Contact With, NOC	61	Wielding or Throwing
11	Cold Objects or Substances	97	Repetitive Motion
14	Abnormal Air Pressure	60	Strain or Injury by, NOC
84	Electrical Current		
II. CAUGHT IN OR BETWEEN		VII. STRIKING AGAINST OR STEPPING ON	
10	Machine or Machinery	65	Moving Parts of Machine
12	Object Handled	66	Objects Being Lifted or Handled
13	Caught In, Under or Between, NOC	67	Sanding, Scraping, Cleaning Operations
20	Collapsing Materials (Slides of Earth)	68	Stationary Object
		69	Stepping on Sharp Object
		70	Striking Against or Stepping On, NOC
III. CUT, PUNCTURE, SCRAPE INJURED BY		VIII. STRUCK OR INJURED BY	
15	Broken Glass		
16	Hand Tool, Utensil (Not Powered)	74	Fellow Worker or Patient
17	Object Being Lifted or Handled	75	Falling or Flying Object
18	Powered Hand Tool, Appliance	76	Hand Tool or Machine in Use
19	Caught, Puncture, Scrape, NOC	77	Motor Vehicle
		78	Moving Parts of Machine
		79	Object Being Lifted or Handled
25	From Different Level (Elevation)	80	Object Handled by Others
26	From Ladder or Scaffolding	85	Animal or Insect
27	From Liquid or Grease Spills	86	Explosion or Flare back
28	Into Openings	81	Struck or Injured, NOC
29	On Same Level		
30	Slipped, Did Not Fall		
32	On Ice or Snow	94	Repetitive Motion
33	On Stairs	95	Rubbed or Abraded, NOC
31	Fall, Slip, Trip, NOC		
IV. FALL OR SLIP		IX. RUBBED OR ABRADED BY	
V. MOTOR VEHICLE		X. MISCELLANEOUS CAUSES	
40	Crash of Water Vehicle	82	Absorption, Ingestion, or Inhalation, NOC
41	Crash of Rail Vehicle	87	Foreign Matter (Body) in Eye(s)
45	Collision or Sideswipe with Another Vehicle	89	Person in Act of a Crime
46	Collision with a Fixed Object	90	Other than Physical Cause of Injury
47	Crash of Airplane	98	Cumulative, NOC
48	Vehicle Upset	99	Other - Miscellaneous, NOC
50	Motor Vehicle, NOC		

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE			
	PHONE NUMBER		EMPLOYER FEIN	JURISDICTION CLAIM NUMBER				
	INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #			
	INDUSTRY CODE							
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
		CARRIER FEIN		POLICY / SELF-INSURED NUMBER	ADMINISTRATOR FEIN			
		AGENT NAME & CODE NUMBER						
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE		
	ADDRESS (INCL ZIP)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE OR (SOC) CODE			
	PHONE NUMBER		# OF DEPENDENTS	EMPLOYMENT STATUS				
				NCCI CLASS CODE				
W A G E	RATE PER:	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	CONTACT NAME / PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED			
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY / ILLNESS CODE		PART OF BODY AFFECTED CODE			
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
	HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.							CAUSE OF INJURY CODE
	DATE RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT		
						<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
O T H E R	WITNESSES (NAME & PHONE #)							
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE					

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000

In-State Toll Free: 1-800-255-7965

FARMINGTON: 599-9746/1-800-568-7310

LAS CRUCES: 524-6246/1-800-870-6826

LAS VEGAS: 454-9251/1-800-281-7889

LOVINGTON: 396-3437/1-800-934-2450

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to \$1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication *Guide to Completing the Employer's First Report of Injury or Illness*, available from the Administration's Albuquerque office (call (505) 841-6072).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

INDUSTRY CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits*.

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Your town, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

NOTICE OF BENEFIT PAYMENT

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE

P U R P O S E	REPORTING PURPOSE		DATE OF PAYMENT / ACTION		CLAIM ADMINISTRATOR CLAIM NO.									
	<input type="checkbox"/> INITIAL PAYMENT	_____			CURRENT CLAIM TYPE		CURRENT CLAIM STATUS							
	<input type="checkbox"/> CHANGE IN PAYMENT	_____			<input type="checkbox"/> MEDICAL ONLY		<input type="checkbox"/> OPEN							
	<input type="checkbox"/> CLOSING PAYMENT	_____			<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> CLOSED							
	<input type="checkbox"/> REOPENED	_____			<input type="checkbox"/> BECAME INDEMNITY		<input type="checkbox"/> REOPENED							
	<input type="checkbox"/> CORRECTION	_____			<input type="checkbox"/> OTHER		<input type="checkbox"/> REOPENED/CLOSED							
C A R R I E R	CARRIER (NAME & ADDRESS)				CLAIM ADMINISTRATOR (NAME & ADDRESS)									
	PHONE # _____		CARRIER FEIN _____		PHONE # _____		ADMIN FEIN _____							
E M P L O Y E R	EMPLOYER (NAME, ADDRESS, & PHONE #)				EMPLOYER LOCATION ADDRESS (If different from mailing address)									
	EMPLOYER FEIN _____		NAICS CODE _____	SIC CODE _____	TYPE OF BUSINESS _____									
E M P L O Y E E	EMPLOYEE NAME (LAST FIRST MI)			DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED							
	ADDRESS (INCLUDE ZIP)				GENDER	MARITAL STATUS	OCCUPATION/JOB TITLE							
	PHONE # _____			# OF CHILDREN _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	U - UNMARRIED SINGLE/DIVORCED M - MARRIED P - SEPARATED K - UNKNOWN	AVERAGE WEEKLY WAGE							
O C C U R R E N C E	DESCRIBE THE ACCIDENT. IDENTIFY HOW THE INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. INCLUDE THE NATURE OF THE INJURY AS WELL AS THE BODY PART AFFECTED.													
	DATE OF INJURY/ILLNESS		IF FATAL, DATE OF DEATH		DATE OF DISABILITY, 1ST DAY		8TH DAY	PRE-EXISTING DISABILITY?						
	_____		_____		_____		_____	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	DATE OF MAX. MED. IMPROVEMENT		DATE CLAIM ADMIN NOTIFIED		% OF IMPAIRMENT	DATE RELEASED TO WORK	DATE RETURNED TO WK	RESTRICTIONS?						
_____		_____		_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO							
B E N E F I T P A Y M E N T S	INITIAL PAYMENT (CIRCLE ONE)				WKLY		LATE		CHANGE IN PAYMENT (CIRCLE ONE)				WKLY	
	TTD TPD PPD PTD DEATH		AMT \$ _____		CODE _____				TTD TPD PPD PTD DEATH		AMT \$ _____			
	Category	Paid To Date	Weekly Amount	Begin Date	# Weeks	# Days	Lump Sum	Category	Paid To Date					
	TTD							Hospital						
	TPD							Physician						
	PPD Scheduled							Therapy						
	PPD Whole Body							Medicine						
	PTD Scheduled							Med. - Other						
	Death							Emplr. - Atty.						
	Unknown							Worker - Atty.						
Compromise							Legal - Other							
Voc. Rehab.							Other							
Funeral														
DATE PREPARED			PREPARER'S NAME				TITLE		PHONE #					
_____			_____				_____		_____					

NM WCA FORM E6.2

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**Phone: (505) 841-6000****In-State Toll Free: 1-800-255-7965****FARMINGTON:** 599-9746/1-800-568-7310**LAS CRUCES:** 524-6246/1-800-870-6826**LAS VEGAS:** 454-9251/1-800-281-7889**LOVINGTON:** 396-3437/1-800-934-2450**FILING INSTRUCTIONS**

WHEN TO FILE: This form MUST be filed within:

- 10 days of the date of initial indemnity payment or medical-only becoming an indemnity; or
- 30 days of the date of change in payment or closing payment for an indemnity claim.
- 180 days of the initial payment for a medical-only claim.

WHERE TO FILE: Send form to: New Mexico Workers' Compensation Administration
 P.O. Box 27198
 Albuquerque, NM 87125-7198
 Attn: Statistics

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to \$1,000.00

INSTRUCTIONS FOR COMPLETION**PURPOSE**

The Notice of Benefit Payment (E6) is a follow-up report to the Employer's First Report of Injury or Illness (E1). It is filed for all indemnity and medical only claims. It is used to report:

- Initial payments of indemnity claims;
- Closing payments of indemnity claims;
- Interim changes in indemnity payments when there is a change in the type of disability payment being paid;
- Initial and closing payments of medical only claims.

ITEMS IN RED ON THE FRONT PAGE OF THIS FORM ARE REQUIRED ON EVERY SUBMISSION. ITEMS IN BLUE ARE ALSO REQUIRED IF AVAILABLE AT THE TIME OF COMPLETION!

Every E6 MUST have the following blocks completed:

REPORTING PURPOSE	SOCIAL SECURITY NUMBER
DATE OF PAYMENT/ACTION	DATE HIRED
CLAIM ADMINISTRATOR CLAIM NO.	GENDER
CURRENT CLAIM TYPE	MARITAL STATUS
CURRENT CLAIM STATUS	OCCUPATION/JOB TITLE
CARRIER	AVERAGE WEEKLY WAGE
CARRIER FEIN	ACCIDENT DESCRIPTION
CLAIMS ADMINISTRATOR	DATE OF INJURY/ILLNESS
ADMINISTRATOR FEIN	DATE OF DISABILITY 1ST DAY
ADMINISTRATOR PHONE	8TH DAY
EMPLOYER	PAID TO DATE (application items)
EMPLOYER FEIN	WEEKLY AMOUNT (applications items)
EMPLOYER NAICS CODE	BEGIN DATE (application items)
EMPLOYEE	DATE PREPARED
DATE OF BIRTH	PREPARER'S NAME, TITLE & PHONE #

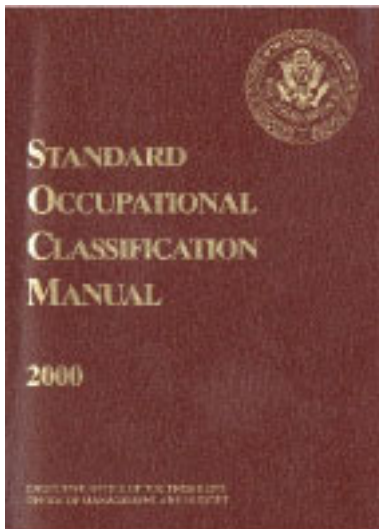
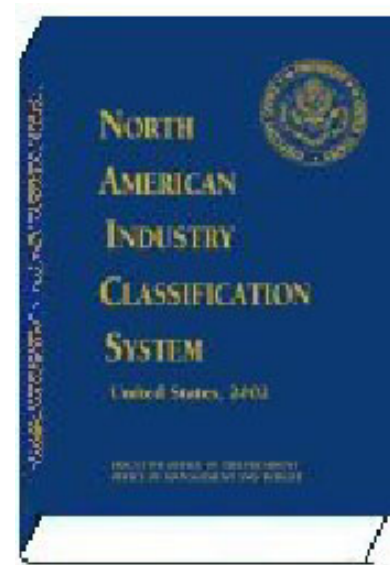
ADDITIONAL BLOCKS TO BE COMPLETED

Other items will vary depending on reporting purpose and on information previously submitted. Instructions on which data items apply under various circumstances are provided in the Workers' Compensation Administration publication **Guide to Completing and filing the Notice of Benefit Payment**. Definitions of data items are also included in the **Guide**.

QUESTIONS and requests for the **Guide** can be addressed to the Statistics section of the Albuquerque office at (505) 841-6072 between 8 a.m. and 5 p.m. Monday-Friday. Alternatively, call the toll-free number (1-800-255-7965) and ask for Statistics.

NOTE: Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E6 may be returned to the sender.

The official **2002 US NAICS Manual** *North American Industry Classification System—United States, 2002* includes definitions for each industry, tables showing correspondence between 2002 NAICS and 1997 NAICS for codes that changed, and a comprehensive index. To order the 1400-page *2002 Manual*, in print, call NTIS at (800) 553-6847 or (703) 605-6000, or check the NTIS web site - [<http://www.ntis.gov/products/bestsellers/naics.asp>]. The 1250-page *1997 Manual*, showing correspondence between 1997 NAICS and 1987 SIC, is also available. The 1997 manual is available on CD-ROM; the 2002 CD can also be pre-ordered at NTIS.



The **Standard Occupational Classification (SOC) System Manual** is available in a soft cover printed version and a Searchable CD-ROM. To order the *Manual*, in print, call NTIS at (800) 553-6847 or (703) 605-6000, or check the NTIS web site - [<http://www.ntis.gov/products/bestsellers/standard-occupational-classification.asp>]. All workers are classified into one of over 820 occupations according to their occupational definition. To facilitate classification, occupations are combined to form 23 major groups, 96 minor groups, and 451 broad occupations. Each broad occupation includes detailed occupation(s) requiring similar job duties, skills, education, or experience.