NMPSIA
Workers' Compensation
Forms & Reporting

Presented by

CCMSI®

Workers' Compensation Self-Insured Program

CCMSI

P.O. Box 30870

Contact Information:

Albuquerque, NM 87190-0870

800-635-0679

WC Fax: 505-888-6794

(different # than Liability Fax)

Workers' Compensation Adjusters

- Jerry Mayo – Supervisor
  - Elaine Elizondo
  - Kim Vallo
  - MaryAnn Campbell
  - Melissa Garcia
  - Mikah Lowe
  - Vanessa Vallejos

505-837-8700 or 800-635-0679

What to do when an accident happens!

- If an employee has an on-the-job accident and need's emergency care, have the employee go to the nearest emergency room or urgent care center, or call 911.
- If an employee does not need emergency care then, you as the employer will either direct them to a specific medical facility or, allow them to make there initial selection of a health care provider.

Notice of Accident Form (NOA) MUST be posted with the Workers' Compensation Poster

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACION DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29 and Section 52-3-16, NMSA 1978
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 y Sección 52-3-16, NMSA 1978

I, _____ (name of employee/*nombre del empleado*) was involved in an on-the-job accident or was disabled *me lesioné en un accidente en el trabajo o fui incapacitado*

by an occupational disease at approximately _____ on _____, 20____.
por enfermedad de oficio aproximadamente (time/*hora*) at (date/*fecha*) *del* 20__.

Employee's social security number: _____
Número de seguro social del empleado:

Where did the accident occur? _____
¿Dónde ocurrió el accidente?

What happened?
¿Qué ocurrió?

_____

Signed: _____
Firma: (employee/*empleado*)

Date: _____
Fecha:

Signed/Notice Received: _____
Firma /Notificación recibida:
(employer or *representative/empleador o representante*)

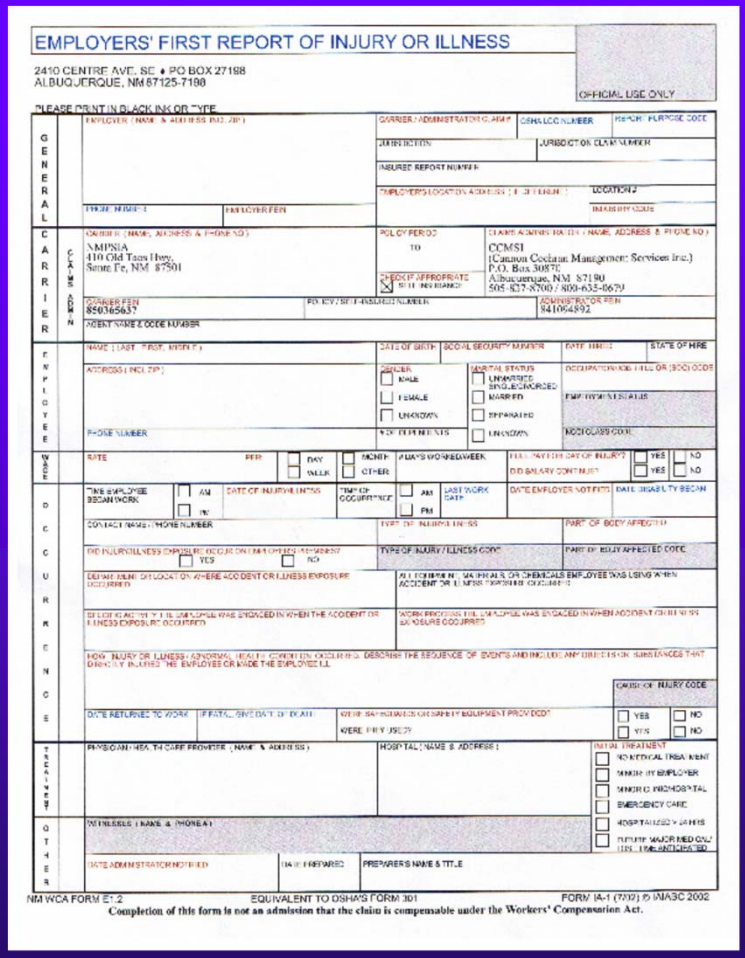
Date: _____
Fecha:

Form NOA-1 (12/01)

Employer/employee: Each keep one copy.
Empleador/empleado: Retener una copia.

— SEE BACK OF THIS FORM —
VER AL REVERSO DE ESTA FORMA –

Employers' First Report of Injury



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

GENERAL
EMPLOYER (NAME & ADDRESS INCL ZIP)
CARRIER / ADMINISTRATOR CLAIM #
OSHA LOC NUMBER
REPORT PURPOSE CODE
JURISDICTION
JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
LOCATION #
PHONE NUMBER
EMPLOYER FEIN
INDUSTRY CODE

CARRIER
CARRIER (NAME, ADDRESS, & PHONE NO.)
NMPSIA
410 Old Taos Hwy.
Santa Fe, NM 87501
POLICY PERIOD
TO
CHECK IF APPROPRIATE
☒ SELF INSURANCE
CLAIM ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
CCMSI
(Canyon Cochran Management Services Inc.)
P.O. Box 30870
Albuquerque, NM 87190
505-827-8700 / 800-635-0679
CARRIER FEIN
850365637
POLICY/SELF-INSURED NUMBER
ADMINISTRATOR FEIN
841064892
AGENT NAME & CODE NUMBER

EMPLOYEE
NAME (LAST, FIRST, MIDDLE)
DATE OF BIRTH
SOCIAL SECURITY NUMBER
DATE HIRED
STATE OF HIRE
ADDRESS (INCL ZIP)
GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN
MARITAL STATUS ☐ UNMARRIED (INCL DIVORCED) ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN
OCCUPATION (JOB TITLE OR SOC) CODE
EMPLOYMENT STATUS
PHONE NUMBER
OF DEPENDENTS
NCCI CLASS CODE

WAGES
RATE
PER ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER
DAYS WORKED/WEEK
FULL WAGES ON DAY OF INJURY? ☐ YES ☐ NO
DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE
TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM
DATE OF INJURY/ILLNESS
TIME OF OCCURRENCE ☐ AM ☐ 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? ☐ YES ☐ NO
TYPE OF INJURY/ILLNESS CODE
PART OF BODY AFFECTED CODE
DESCRIBE JOINT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
DESCRIBE ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED OR 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? ☐ YES ☐ NO
WERE THEY USED? ☐ YES ☐ NO

TREATMENT
PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)
HOSPITAL (NAME & ADDRESS)
INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ TREATED BY EMPLOYER
☐ TREATED IN HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HRS
☐ FUTURE MAJOR MED ONLY (IES, UNANTICIPATED)

OTHER
WITNESSES (NAME & PHONE #)
DATE ADMINISTRATOR NOTIFIED
DATE PREPARED
PREPARER'S NAME & TITLE

NM WCA FORM E: 2 EQUIVALENT TO OSHA'S FORM 301 FORM IA-1 (7/02) © IAIABC 2002

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

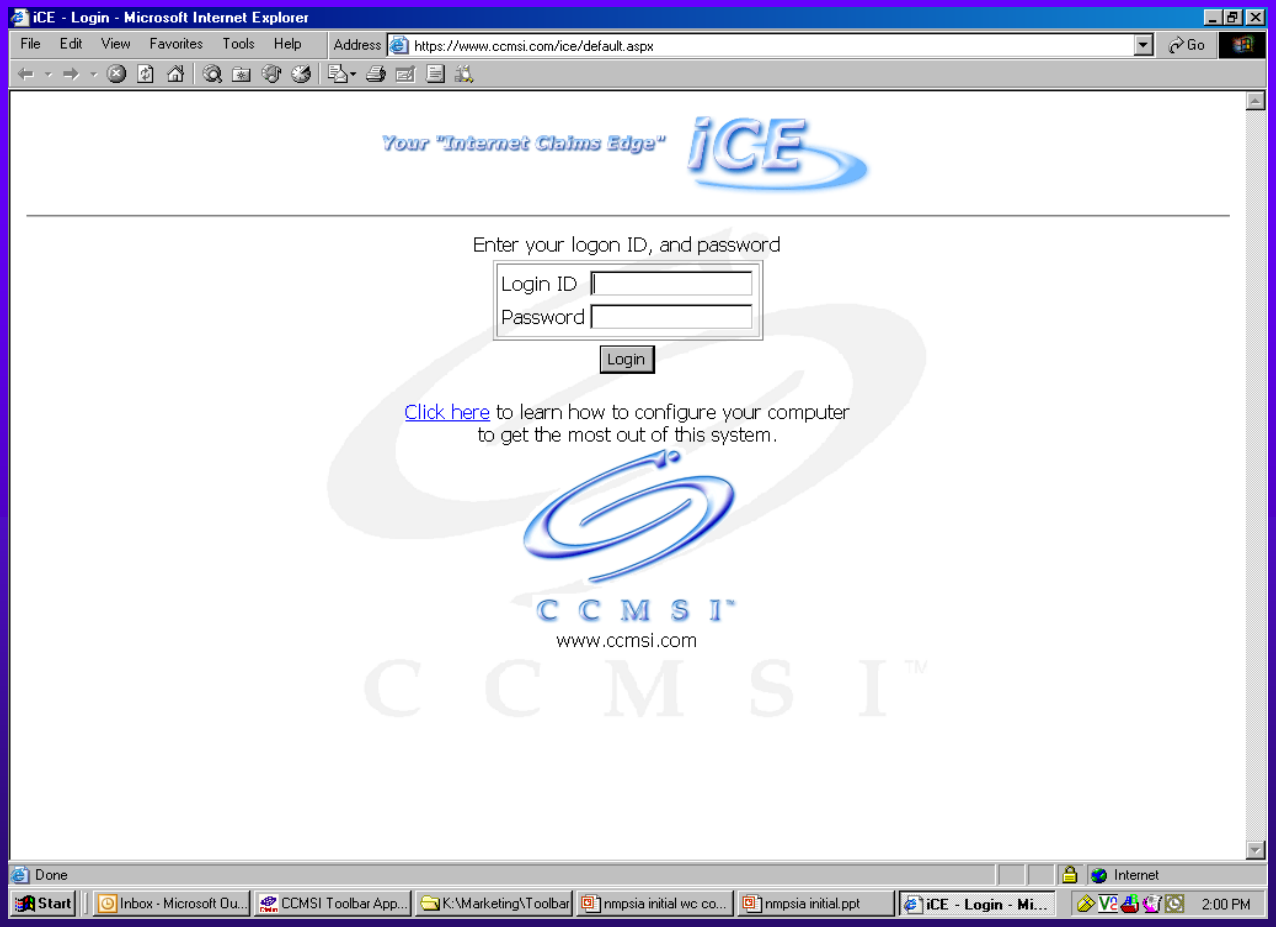
Report Completion

Please submit the Employers' First Report of Injury/Illness as soon as possible, even if you don't have all the information

Please use iCE or fax completed forms to:

- **WC Fax: 505-888-6794**

What is iCE?
Internet Claims Edge



Mandate Same Day Reporting from the Worker

- Studies show that on average, the longer the time between an injury and the initial report to your claims administrator, the more expensive the claim is.
- To help lower your costs, your policy should require workers to report any accident the same day it occurred.

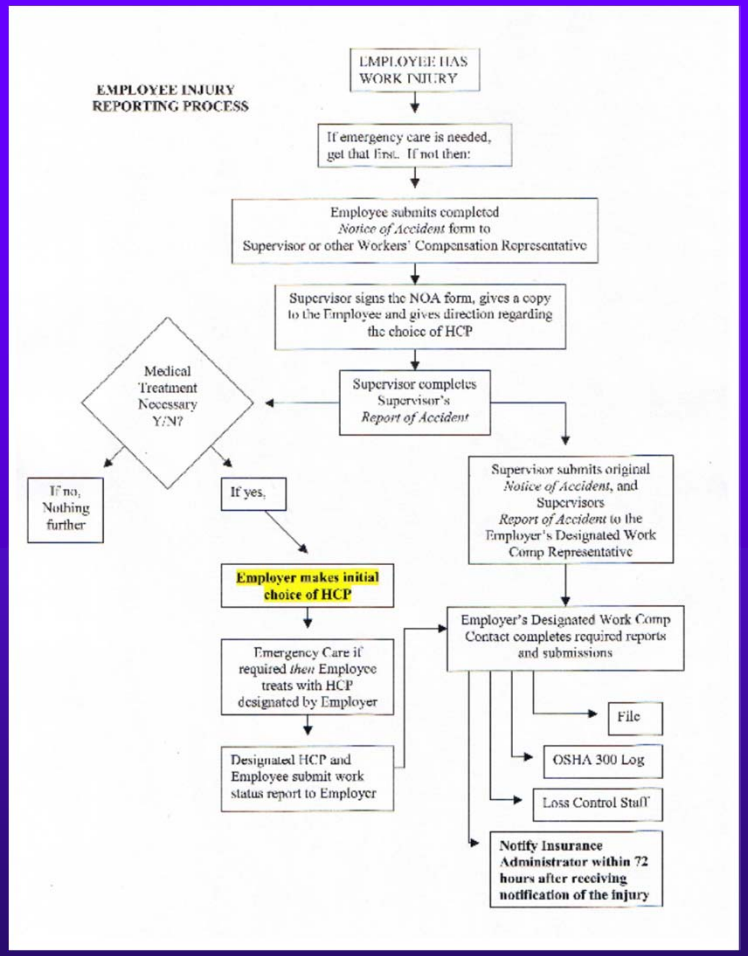
Report Timely

- The New Mexico Workers' Compensation Administration requires the employer to submit the claim to their administrator within 72 hours of:

(a) actual knowledge of the accident by the employer; or

(b) presentation of a notice of accident form to the employer.

Injury Reporting Process ***Employers' Choice of HCP***



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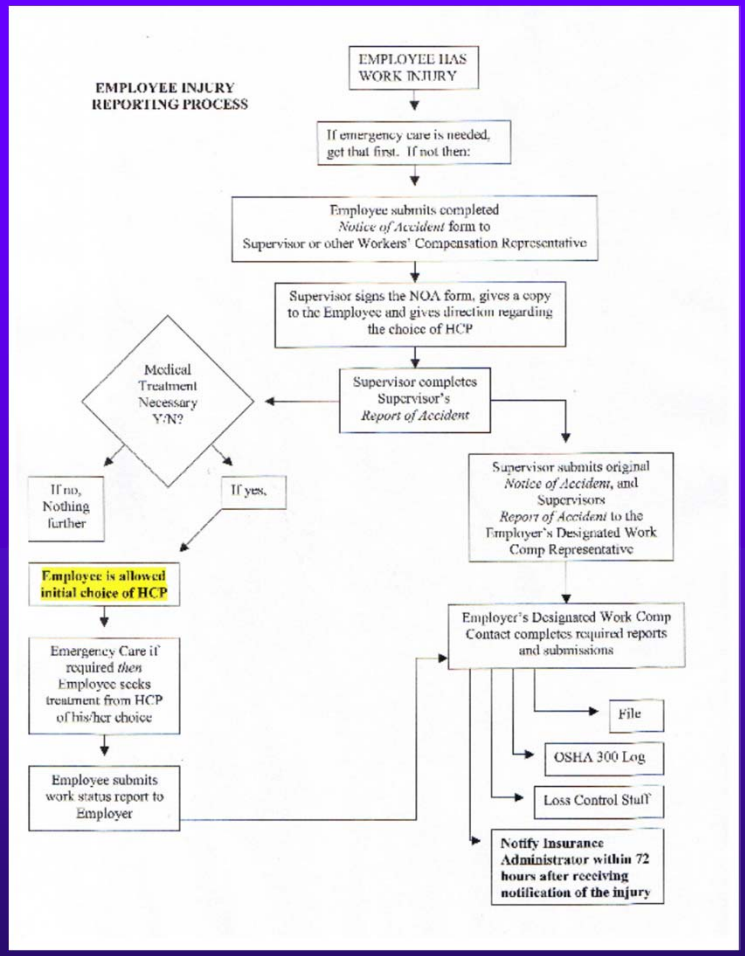

Initial Choice of Health Care Provider (HCP)

- The initial selection of a health care provider (HCP) is a very important part of a New Mexico workers' compensation claim and must be understood and documented by the employer!

HCP Selection for the First 60-Days

- **Section 52-1-49 NMSA 1978**
  - **The employer shall initially either select the health care provider for the injured worker or permit the injured worker to make the selection**
  - **After the expiration of the initial sixty-day period, the party who did not make the initial selection may select a health care provider of his/her choice**

Rules & Regulation 11.4.4.11.C

(1) Emergency care: The provision of emergency medical care shall not be considered a choice of a treating HCP by the employer or worker.

(Medical treatment after emergency care is considered to be a choice)

Employer Shall Decide the Initial Selection of HCP

(a) The employer shall decide either to select the initial HCP or to permit the worker to select the initial HCP. The decision made by the employer shall be made in writing to the worker. Employer may communicate the decision to select the initial HCP or to permit the worker the selection by any method reasonably calculated to notify the worker.

Notification Regarding Initial Selection of HCP

The employer may use a wallet card, a poster stating the decision posted with the WCA poster, a flyer inserted semi-annually with pay checks, or any other method employer knows will be successful in alerting the worker.

Employer is Presumed to have Selected the Initial HCP

(b) If the decision of the employer is not communicated in writing to the worker, the employer shall be presumed, absent other evidence, to have selected the HCP initially

IMPORTANT NOTICE
Employers' Choice of HCP

MEMORANDUM

TO: **ALL (insert school district) EMPLOYEES**

FROM: **(specific person & title)**

DATE:

SUBJECT: **IMPORTANT NOTICE REGARDING NEW MEXICO WORKERS' COMPENSATION**

TIMELY REPORTING
The New Mexico Workers' Compensation Law, section 52-1-29 (A) NMSA, requires an injured worker to give written notice of an accident. The notice of accident must be provided within 15 days of when the worker knew or should have known of the accident occurrence. A notice of accident must be provided to the Employer, and Employer's agent, or another person acting within supervisory capacity.

If you have an accident at work please complete a Notice of Accident Form (located with the Workers' Compensation poster). Ask your supervisor to sign and date the form. After it is signed, keep one copy and give your Employer or supervisor the other copy.

PERSONNEL ASSESSMENT FEE
All employers covered by the New Mexico Workers' Compensation Act must pay the workers' compensation personnel assessment fee. The fee is an administrative payment to the State (a tax) and is not for payment of or to provide insurance coverage.

NOTICE OF FIRST SELECTION OF HEALTH CARE PROVIDER – EFFECTIVE (date if appropriate)

If you are injured while on the job, you are to:

1. Immediately notify your supervisor of the injury whether or not medical attention is required.
2. If emergency medical attention is required, seek emergency treatment at the nearest emergency room or urgent care facility. If non-emergency medical attention is required, **treatment will be provided only by the following facility.**

(name of facility)
(address – line)
(address – line)
(telephone number)

Under current workers' compensation law, the Employer has the right to select the first health care provider. If, after 60-days you wish to change from the health care provider first selected by your Employer, you will need to notify your adjuster at CCMSI in writing (see address below).

If you have any questions regarding this matter, please contact your adjuster at:

CCMSI
P.O. Box 30870
Albuquerque, NM 87190-0870
In Albuquerque: 505-837-8700
Outside of Albuquerque: (800) 635-0679

Or you can call an ombudsman at the New Mexico Workers' Compensation Administration: In Albuquerque: (505) 841-6000 or Outside of Albuquerque: (866) 967-5667

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If you are injured while on the job, you are to:

1. Immediately notify your supervisor of the injury whether or not medical attention is required.
2. If emergency medical attention is required, seek emergency treatment at the nearest emergency room or urgent care facility. If non-emergency medical attention is required, **you will need to seek treatment with a health care provider of your choice.**
3. Immediately after your treatment, notify your supervisor or designated workers' compensation contact and provide the name of the physician or clinic that is treating you as well as a physician note explaining your work restrictions and status.

Under current workers' compensation law, the Employer has the right to select the first health care provider or can transfer that right to the injured worker. **The policy of your Employer is to allow the injured worker to make the first choice of health care provider.**

If, after 60 days the Employer wishes to exercise their right to change you to a different health care provider than the one you first selected, your adjuster at CCMSI will notify you in writing.

If you have any questions regarding this matter, please contact your adjuster at:

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Forms located at www.NMPSIA.com

- All forms or documents shown in this presentation (except the NOA) are located under the Risk Division tab at:

  http://nmpsia.com/index.html

- To order Workers' Compensation Posters or Notice of Accident (NOA) forms, please email your request to:

  wcaposter@state.nm.us

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