STATE OF NEW MEXICO

WORKERS' COMPENSATION ADMINISTRATION

FORM LETTER TO HEALTH CARE PROVIDER

TO: HEALTH CARE PROVIDER

RE: Worker:_____ WCA No.:

DOB: _____/_____/_____/ SSN: _____/_____/_____/

Attached is a release of medical information by the Worker/Patient. The information requested in this letter is necessary to evaluate the Worker's legal claims. By promptly completing these forms, you speed the process of evaluation, including whether medical bills should be paid by the Insurance Carrier. Please answer all questions which you believe to be pertinent. Your answers must be based upon reasonable medical probability.

1. Who referred Worker to you for treatment?

2. Date of Worker's most recent visit or treatment:

   What is your diagnosis of the condition(s) for which you have treated the Worker? _____

   _____

   _____

3. In your opinion, are the conditions or complaints for which you have treated the Worker causally related to an on-the-job injury?
   Yes____ No
   Date of Injury:

5. Is the Worker suffering from a disease that, in your opinion, is related to employment? Yes____ No____ Date of occurrence:

6. Indicate the period of time the Worker has been unable to work:

7. Is Worker able to return to work? Yes___ No
   Any Restrictions?
   If no, when do you anticipate a return to work?

8. Has the Worker reached the date after which further recovery from, or lasting improvement to, an injury can no longer be reasonably anticipated (MMI)?
   Yes____ No____ Date of MMI:

9. If the Worker has reached MMI, please indicate your opinion as to the percentage of the Worker's anatomical or functional abnormality existing after the date of MMI:
   a) Percentage of impairment, if any:
   b) Whole Body or body part:
   c) Indicate which edition of AMA Guides used:

10. Has a Physical Capacities Assessment or Functional Capacity Evaluation been performed? Yes____ No
    Was the evaluation performed by a licensed physical therapist or occupational therapist? Yes____ No

11. Can the Worker:
    a) Lift over 50 pounds occasionally or up to 50 pounds frequently? Yes___ No
    b) Lift up to 50 pounds occasionally or up to 25 pounds frequently? Yes___ No
    c) Lift up to 20 pounds occasionally or up to ten pounds frequently, and either walk or stand to a significant degree, or sit most of the time with a degree of pushing and pulling arm or leg controls or both? Yes___ No
    d) Lift up to ten pounds occasionally or up to five pounds frequently, and occasionally walk or stand to carry out job duties? Yes___ No
    Comments:_____

12. Please describe any other restrictions on Worker's activities not covered above:

13. Other remarks:

14. Have you made any referrals to other health care providers, hospitals or institutions?
    Yes___ No____ If yes, provide the name:

15. Please attach a copy of any unpaid bills.

The maximum allowable fee for this form is $45.00. The fee for copying of medical records and reports for the first ten (10) pages is $10.00, and $.20 cents for each additional page.

I hereby swear and affirm that the foregoing responses or opinions are true and correct, to a reasonable medical probability, on pain and penalty of perjury.

Date

Signature of Physician

_____
Address

City/State/Zip

( )
Telephone Number

SEND COMPLETED FORM TO:

New Mexico Mutual Casualty Company, P.O. Box 27810, Albuquerque, NM 87125