NOTICE OF CHANGE OF HEALTH CARE PROVIDER
UNDER AUTOMATIC RIGHT OF SECOND SELECTION
NEW MEXICO WORKERS' COMPENSATION LAW

This notice is sent by one party in a New Mexico workers' compensation case to the other party in the case. The party sending the notice claims to have the automatic right to change health care provider, under Section 52-1-49 of the Workers' Compensation Law or Section 52-3-15 of the Occupational Disease Disablement Law of New Mexico.

The party sending this notice hereby notifies the other party that the health care provider whose services are covered under the workers' compensation claim will be changed, effective 10 days after the date this form is postmarked or delivered to the other party. The party receiving this notice may object to the change, by filing a Health Care Provider Disagreement Form" with the court of the New Mexico Workers' Compensation Administration. If the form is not filed **within 3 days**, this change is binding upon the party who received the notice. If a Health Care Provider Disagreement Form is filed at a later date, the change specified in this notice remains in effect until decision of the court.

The party sending this notice is: ______________________________

This notice is sent to: ______________________________

Workers Name: ____________________ Employer's Name: ____________________

Worker's Address: ____________________ Employer's Address: ____________________

Worker's Telephone Number: ( ) - ____________ Employer's Telephone Number: ( ) - ____________

Insurance Company: ____________________ Claims Representative: ____________________

Address: ____________________ Telephone Number: ( ) - ____________

Worker's Attorney, if any: ____________________ Employer's Attorney, if any: ____________________

Address: ____________________ Address: ____________________

Date of Accident: ____________________ County of Accident: ____________________

Type of injury: ______________________________

Name of doctor/provider now providing treatment: ______________________________

Address of doctor: ____________________ Telephone Number: ( ) - ____________

Name of new doctor/provider:
(Must be licensed in New Mexico): ____________________ Telephone Number: ( ) - ____________

Address of new doctor: ______________________________

Signature of person sending this notice: ____________________ Date: ____________

TO THE PERSON RECEIVING THIS NOTICE: Your rights may be affected by your failure to respond to this notice. If you need assistance and are not represented by an attorney, contact an Ombudsman of the Workers' Compensation Administration, at one of the following telephone numbers:

Albuquerque: (505) 841-6000 or 1 (800) 255-7965
Farmington: (505) 599-9746 or 1 (800) 568-7310
Las Cruces: (505) 524-6246 or 1 (800) 870-6826
Las Vegas: (505) 454-9251 or 1 (800) 281-7889
Lovington: (505) 396-3437 or 1 (800) 934-2450

WORKER: If you have received this notice, you are required to change from your current doctor to the new doctor named above in 10 days, unless you respond to this notice within 3 days.