CHOICE OF HEALTH CARE PROVIDER FORM

It is your employer's policy to allow an employee who is injured on-the-job to choose their initial health care provider.

Please provide the below claims information to the medical provider of your choice for proper billing:

New Mexico Self-Insurers' Fund
P.O. Box 846
Santa Fe, New Mexico 87504
Phone: (505) 982-5573
Fax: (505) 820-0670

By signing below, you understand and acknowledge that your employer is not directing your initial Health Care Provider Choice. We reserve the right to change your Health Care Provider to the provider of our choice after the first sixty days.

Claimant Name : ____
(Please Print)

Claimant's Signature: ______________________ **Date:** _____/_____/_____

Witness Name: ____
(Please Print)

Witness's Signature: ______________________ **Date:** _____/_____/_____

updated: 01/2014

New Mexico Self-Insurers' Fund
P.O. Box 846
Santa Fe, New Mexico 87504
(800) 432-2036 ♦ Fax (505 820-0670