New Mexico Workers' Compensation Administration
Report to the Enforcement Bureau

Name of Party Suspected of Wrongdoing: _____

Phone #: _____ Address: _____

City, State, Zip: _____

If Individual: SSN: _____ DOB or Age _____ Employer: _____

Employer's Phone #: _____ Address: _____

City, State Zip: _____

This person/organization is a: ❒ Worker ❒ Employer ❒ Insurance Agency ❒ Case Manager ❒ Insurance Carrier ❒ Claims Adjuster ❒ Health Care Provider ❒ Attorney For Insurer ❒ attorney for worker ❒ other (describe) _____

Why do you suspect a wrongful act is being committed? _____

Please attach/send in any documentation, pictures, etc.

Has this matter been heard/scheduled to be heard in mediation or formal hearing? ☐ Yes ☐ No

If Yes, WCA Case #: _____

INFORMATION ABOUT YOU

Relationship to Above Named Party: ❒Worker ❒Employer ❒Insurance Carrier ❒Attorney ❒Other Gov./Law Enforcement Agency ❒Department of Insurance ❒Health Care Provider ❒Anonymous ❒Friend, Neighbor or Relative of Subject ❒WCA Employee

Name _____ Phone _____

Address: _____

City, State, Zip: _____

May we use your name? _____ Are you willing to assist at a later date? _____

Have you called before? Are you willing to testify in court if needed?