

Use these instructions to help you file a claim. Simply log on to New Mexico Mutual at newmexicomutual.com. If you need help filing a claim, call us at 505.345.0127.

Ways of filing claims:

- **Online:** New Mexico Mutual | New Mexico's experts in workers' compensation.
- **Phone:** (505) 343-7730
- **Email:** First Report of Injury Form (E-1): NMMClaims@newmexicomutual.com
- **Fax:** (505) 345-0656

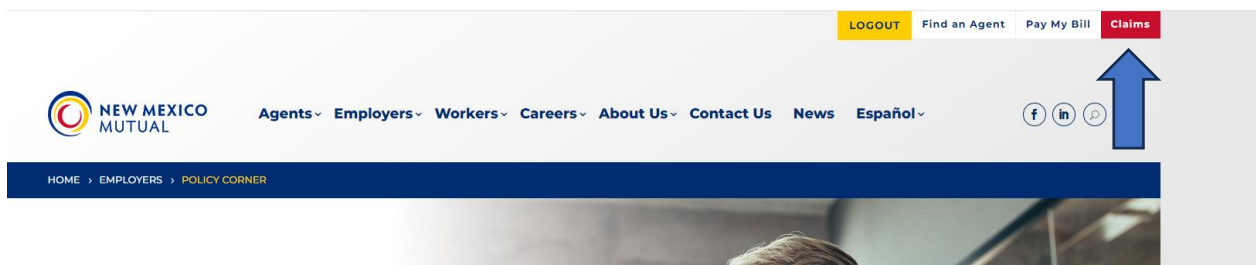
Required Information:

- First & Last name of employee
- Date of Birth
- SSN
- Date of Hire
- Job Title
- Employees address and phone number
- Date of injury
- Date employer notified
- Body part injured (left or right)
- Date returned to work
- Brief description on what happened
- Did they seek medical attention and where
- Employer contact information

Must be registered on the website to file a claim online.

Steps to file a claim online:

1 Click on Claims



2

Click File a Claim

NEW MEXICO MUTUAL

Home FAQ

Claims

INFORMATION THAT YOU ACCESS OR SUBMIT THROUGH THE SITE MAY INCLUDE PERSONAL OR OTHERWISE CONFIDENTIAL INFORMATION WHICH IS PROTECTED BY LAW. YOU ARE SOLELY RESPONSIBLE FOR THE SECURITY AND USE OF ANY INFORMATION THAT YOU ACCESS ON THE SITE. YOU ACCEPT SOLE LIABILITY FOR YOUR DISCLOSURE OR USE OF ANY SUCH INFORMATION FOR ANY IMPROPER PURPOSE.

Search

[File a Claim](#)

Claim Number	Date of Loss	Status	Policy	Adjuster Name	Adjuster Email

My Quick Links

- [Return to Homepage](#)
- [File a Claim](#)
- [FAQ](#)

New Mexico Mutual
Your Security. Our Passion.
Follow Page
Timeline
Messages

3

Provide date your worker was injured.

If the injury developed over time, enter the day the worker told you about the injury.
*All fields that have an asterisk must be completed.

NEW MEXICO MUTUAL

Home FAQ

New Claim

Claim Information

Select Policy

Loss Information 74761

* Date of Injury

Select A Policy

Policy Number	Type	Effective	Expires

Cancel [Next](#)

4

Provide as much information about the accident as you are able.

NEW MEXICO MUTUAL

Home FAQ

New Claim

Claim Information

Select Policy

What

Injury

Where

Contact Details

Summary

Describe what happened

* Indicate who or what caused the incident, and provide other details that would be helpful.

* Date Employer Notified

* Has the worker sought medical care, or do you expect the worker to seek medical care?

Yes No

5

Provide information about the injured worker

Injured employee

* Prefix

* First Name

* Last Name

* Phone Number

* Social Security Number

* Date of Birth

* Gender

* Marital Status

* State Of Hire

* Date Of Hire

* Occupation / Job Title

* Department

* Gross Weekly Wage

* Address Line 1

Address Line 2

* City

* ZIP Code

* State

6

Click 'Next'

Cancel

Previous

Next

7

Provide details about the injury:

Important

***All claims in a draft status will show a temporary claim number beginning with a T.**

Claim Information

Select Policy

What

Injury

Where

Contact Details

Summary

New Claim

T000143033

Injury Details

* Injured Body Part(s)

* Cause of Injury / Source

* Detailed Cause / Source

* Primary Injury Nature

* Detailed Injury Nature

Injury/illness result in death?

* Is worker expected to miss at least one week of work?

* Last work Date

Date returned to work

Body Injuries

8

Provide details about any available medical care that has been received and click 'next'.

Medical Treatment

* Medical attention required?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Initial Treatment	Select Initial Treatment
Doctor's First Name	
Doctor's Last Name	
Examination Date	MM/dd/yyyy

Save and Exit

Previous

Next

9

Provide the details about where the accident occurred and click 'next'.

Where did this happen?

Where did this happen?

- ☒ Use my policy address
☐ Specify full address manually

* Select Address	--Choose Address--
Address	-
City	-
ZIP Code	-
State	New Mexico

Save and Exit

Previous

Next

10

Provide us with the details for the person you would like us to contact to obtain additional information about this claim. Click 'next'.

Primary Contact Details

Please provide us with contact information for the employer's primary contact person. The adjuster will contact this person with any questions they have about the claim.

Contact	Please Select
* First Name	
* Last Name	
* Address Line 1	
Address Line 2	
* City	
ZIP Code	
* State	New Mexico
* Primary Phone Number	Work
Home Phone	
* Work Phone	
Mobile Phone	
Email	

Save and Exit

Previous

Next

11

Confirm the information provided and submit the claim.
***Must “submit claim” to receive claim number.**

New Claim

Summary

Policy Number

When?

Where?

Contact Person

Save and Exit

Previous

Submit Claim

12

You will be provided with a confirmation that the claim was submitted and the claims information



Claim Was Successfully Submitted

Claim Reference Number 0000150923

Adjuster Name Default Owner

Adjuster Email -

Adjuster Phone 213-555-8164

Your claim has been submitted, click below to keep obtain a copy for your records.

Back to Home

[Click to download the copy of Employers First Report of Injury](#)



**You can download a
copy of report here**