NOTICE OF TORT CLAIM

In order to submit your claim, you must complete this form and submit it to the Mayor of the Municipality within **NINETY (90)** days of the occurrence. The Municipality will then forward your claim to the New Mexico Self-Insurers' Fund for investigation. You may expect to be contacted by a Fund representative regarding your claim.

To Municipality (or Public Entity) of ______________________________

Claimant: ______________________________

DOB: ____/____/____* SSN: ___-___-___* Gender: ______Male ______Female

Address:______________________________ City:______________ Zip: __________

Home Phone: (____)____-______Cell: (____)____-______Work: (____)____-______

Date of Occurrence:____/____/____ Time of Occurrence:________ AM or PM (Circle One)

Address or Detailed Location of Occurrence:______________________________

Please describe what happened: (continue on blank sheet if necessary)______________________________

____

____

____

Witness Name:______________________________ Contact #: (____)____-______

Witness Name:______________________________ Contact #: (____)____-______

Please list all persons and/or property for which you are claiming damages:

1. ______________________________ $__________

2. ______________________________ $__________

3. ______________________________ $__________

4. ______________________________ $__________

TOTAL AMOUNT OF CLAIM $__________

Please attach all estimates, bills, or other information to support the amount of your claim. Please allow ten days before contacting the Fund to allow adequate to investigate your claim. Questions may be directed to the New Mexico Self-Insurers' Fund Liability Claims Unit at (800) 432-2036 or (505) 982-5573.

______________________ ______________________ ____/____/____

Signature Printed Name Date

***This information is required by the federal government. No payment can be made without this information.**

THIS SIDE FOR MUNICIPAL/PUBLIC ENTITY OFFICIAL USE ONLY.

Notice of Tort Received By ______________________________ ______________________________
Name Title

Date: ______/_____/_____ Time: ____________ AM/PM (Circle One)

Persons having knowledge of the circumstances surrounding this claim:

Name: ____ Phone: (_____) _____-________

Name: ____ Phone: (_____) _____-________

Name: ____ Phone: (_____) _____-________

Name: ____ Phone: (_____) _____-________

Attached are the following reports, statements or other documentation which support our understanding of the facts relating to this claim:

1. ____

2. ____

3. ____

4. ____

Please describe any other information which you feel is pertinent to this claim: ____________________

____

____

____

____

Submitted by:__________________________________ __________________________________
Signature Print Name

Title: ______________________________________ Phone: (_____) _____-________

Upon receipt of this claim, please provide the above information and *immediately* email to liabilityclaims@nmml.org.

New Mexico Self-Insurers' Fund
P.O. Box 846
Santa Fe, NM 87504
(800) 432-2036 or (505) 982-5573
Fax (505) 820-0670

Center for Medicare/Medicaid Services (CMS) Verification Form

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the New Mexico Self-Insurers' Fund to report specific information contained within this form to the Center for Medicare and Medicaid Services.

In order for us to process your claim, you must complete this form and mail it back to our office so that we may comply with this federal regulation. Please note that the claimant's information will have no effect on the outcome of any claim investigation we conduct and does not imply any liability on behalf of the New Mexico Self-Insurers' Fund and/or its insured.

CLAIMANT INFORMATION			
Last Name		First Name	Middle Initial
Social Security Number - -	Date of Birth / /	Gender ☐ Male ☐Female	
Address			
City		City	Zip
Is the claimant presently, or ever been, enrolled in Medicare, Medicaid or Disability? Medicare ☐ Yes ☐ No Medicaid ☐ Yes ☐ No Disability ☐ Yes ☐No			
If yes, please list the Medicare Claim # from your red, white and blue Medicare card:			
Name of Person Completing This Form if Claimant is Unable (Please Print):			
Last Name		First Name	Middle Initial

I declare and affirm under the penalty of perjury that the answers made herein are true to the best of my knowledge, information and belief.

____________________ ____________________
Signature Print Name

____________________ ____________________
Date Telephone #

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