Date: _____

Workers' Compensation Fraud Intake Form

COMPLAINT IS AGAINST	COMPLAINT INVOLVES
ALLEGED SUSPECT NAME: _____ DOB: _____ SS#: _____ ADDRESS: _____ _____ HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____	**ALLEGED VICTIM** EMPLOYER NAME: _____ ADDRESS: _____ _____ PHONE: _____ CARRIER: _____ CARRIER CLAIM#: _____ WC #: _____ DOI: _____

COMPLAINANT'S STATEMENT WITH DETAILS OF ALLEGED OFFENSE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

LIST OF WITNESSES WHO CAN VERIFY DATES/DETAILS OF THE INCIDENT:

NAME: ADDRESS: CITY, STATE, ZIP: PHONE: BE SPECIFIC:

WITNESS #1:

_____

WITNESS #2:

_____

COMPLAINANT'S INFORMATION:

COMPLAINANT'S NAME: _____ REMAIN ANONYMOUS: Yes:_____ No:_____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

RELATIONSHIP TO THE PERSON/BUSINESS THEY ARE REPORTING: _____

Please mail the completed form to the following address:
Workers' Compensation Fraud Investigation Unit
633 17th Street, Suite 900, Denver CO 80202-3660