AB 469 Third Party Reporting Form

Pursuant to AB 469 Sec 19.2. On or before December 31 of each year, a third party shall report requested information for the immediately preceding 12 months on this form.

<table>
<thead>
<tr>
<th>Third Party Name:</th>
<th>DBA (if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td>Physical Address:</td>
</tr>
<tr>
<td>Third Party Type:</td>
<td>Third Party Phone:</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>Contact Phone:</td>
</tr>
<tr>
<td>Contact E-mail Address:</td>
<td>Contact Fax:</td>
</tr>
</tbody>
</table>

1. Number of disputed payments by out-of-network providers for medically necessary emergency services that were settled without arbitration: ________________________________

2. Types of provider of health care that settled disputed payments (list all that apply):

   ________________________________________________________________

3. Amounts of settled payments (list all that apply):

   ________________________________________________________________

4. Number of new contracts with providers of health care that provide medically necessary emergency services: ________________________________

5. Types of provider of health care that entered into new contracts (list all that apply):

   ________________________________________________________________

6. Number of terminated contracts with providers of health care that provide medically necessary emergency services: ________________________________
7. List reasons for terminated contracts with providers of health care that provide medically necessary emergency services (list all that apply):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

You may use additional pages if necessary.

I attest that the information provided in this report is true and accurate to the best of my knowledge.

______________________________________
Authorized Representative Name (please print)  Title

______________________________________
Signature  Date

Please mail completed form to:

Office for Consumer Health Assistance
Attn: Consumer Health Advocacy Specialist
555 E. Washington, Ste 4800
Las Vegas, Nevada  89101

Form may also be sent by:
Fax to: (702) 486-3586  |  Email:  CHA@govcha.nv.gov