Instructions Section 1: To be completed by the Provider/Facility prior to submitting a Request for Arbitration

Before submitting a Request for Arbitration verify each of the following:

1. **The Third Party, that is associated with the claim, is an issuer of a Health Benefit plan as defined by NRS 695G.019, a Public Employees' Benefits Program (PEBP), and/or self-funded and has opted to participate in the provisions of NRS 439B.754.**
   - To verify if the Third Party has opted into the provisions of NRS 439B.754, please review the **Third Party Opt-In List** on the Office for Consumer Health Assistance website: **http://dhhs.nv.gov/Programs/CHA/**

2. **The policy that is associated with the claim was sold within the state of Nevada.**

3. **The Provider/Facility was an Out-of-Network Provider (i.e. not contracted) with the Third Party on the date the medically necessary emergency services were provided.**

4. **With the Third Party, the arbitration contact information, to include:**
   - Third Party Arbitration Contact name
   - Third Party Arbitration Contact phone number
   - Third Party Arbitration Contact email address

5. **The total amount billed for the entire claim is less than $5,000.00.**

6. **The Out-of-Network Provider/Facility requested the additional amount from the Third Party within 30 business days after receiving initial payment.**
   - **For example:** The Out-of-Network Provider/Facility received the initial payment for the claim from the Third Party on 07/01/2020. Therefore, the Provider/Facility must request the additional amount from the Third Party on or before 8/12/2020 (30 business days later).

7. **The Out-of-Network Provider/Facility submits a request for arbitration if the Third Party *refuses* to pay the additional amount requested by the Out-of-Network Provider/Facility or *fails* to pay that amount within 30 business days after receiving the request for the additional amount.**

   a) ***Refusal* to pay Submission Timeframe:** Request for Arbitration must be submitted not later than 30 business days from the date the Third Party notified the Provider/Facility of their ***refusal*** to pay the additional amount requested.

      ❖ **Example:** The Provider has documentation with a date of 07/10/2020 from the Third Party refusing to pay the additional amount requested. The Request for Arbitration must be submitted between 07/10/2020 and 30 business days from 07/10/2020, which is 08/21/2020. Documentation showing proof of refusal to pay with a date of 07/10/2020 must be submitted with the application. The Request for Arbitration is invalid if submitted after 8/21/2020.

   OR

   b) ***Failure* to pay Submission Timeframe:** Request for Arbitration must be submitted not later than 30 business days from the date the Provider/Facility requested the additional amount from the Third Party and the Third Party ***failed*** to respond to the request.

      ❖ **Example:** The request for the additional payment was submitted to the Third Party on 07/15/2020. The Third Party failed to respond to this request to pay the additional amount within 30 business days, i.e. by 08/26/2020. A Request for Arbitration submitted prior to 8/26/2020 is invalid.

Instructions Section 2: Completing the Request for Arbitration Application

1. **Visit the Office for Consumer Health Assistance website to ensure the most up to date application is completed: Request for Arbitration Claims Under $5,000. As the arbitration process evolves, the Office for Consumer Health Assistance continues to make revisions as identified in the processing of applications and feedback received.**

2. **To be considered complete, all fields on the application must be completed and all supporting documentation submitted must be consistent with information entered on the application. Any discrepancies between the supporting documentation and the application will be returned to the Out-of-Network Provider/Facility for clarification.**
    - For example: the date on the documentation submitted as proof of the date the Provider requested additional payment must match the date submitted on the application.

Instructions Section 3: Sample Application

CONFIDENTIAL

Pursuant to NRS 439B.754 (10), except as otherwise provided, any decision of an arbitrator and any documents associated with such a decision are confidential.

REQUEST FOR ARBITRATION
CLAIMS UNDER $5,000

To request a list of randomly selected arbitrators, pursuant to subsection 3 of NRS 439B.754, to arbitrate a dispute over a claim of less than $5,000, an out-of-network provider must submit a request to the Department. If the out-of-network provider submits the request because the third party has refused or failed to pay the additional amount requested by the out-of-network provider pursuant to subsection 2 of NRS 439B.754, the out-of-network provider must submit the request not later than 30 business days after:

a) The date on which the third party notifies the out-of-network provider of the refusal to pay the additional amount.

b) The third party failed to pay the additional amount for 30 business days after receiving a request for the additional amount.

PROVIDER/FACILITY INFORMATION

Provider type for which the arbitration application is being submitted:

☐ **Out-of-Network Provider (OONP)** ☐ **Out-of-Network Facility (OONF)**

Provider/Facility Name:	**Provider/Facility DBA:**
Provider Type and Specialty (OONP only):	**Address for the location where the medically necessary emergency services were provided:**
Provider/Facility Phone:	
Provider/Facility Fax:	
Provider/Facility Email:	
Has the Provider/Facility ever contracted with the Third Party? **Yes** ☐ **No** ☐	**If yes, date contract terminated (month/ year):**

This field does not apply to facilities.

Enter the physical address where the services were provided.

If "Yes" is checked, enter the month and year in the box to the right.

PROVIDER/FACILITY ARBITRATION CONTACT

Provider/Facility Contact Name:	**Provider/Facility Contact Mailing Address:**
Provider/Facility Contact Phone:	
Provider/Facility Contact Fax:	**Provider/Facility Contact Email:**

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THIRD PARTY INFO & ARBITRATION CONTACT

Third parties must meet the criteria as defined in NRS 439B.736 to participate in the provisions of NRS 439B.700 to NRS 439B.760. If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the Third Party is inapplicable to these provisions, the request for arbitration will be denied.

This contact information is specific to the person who handles Arbitrations.

Click here to select an option from the dropdown.

No other information should be entered in this field.

Third Party Name:	**Third Party Type:** Selection Required*
Third Party Arbitration Contact Name:	**Third Party Arbitration Contact Mailing Address:**
Third Party Arbitration Contact Phone:	
Third Party Arbitration Contact Email Address:	

DISPUTE INFORMATION

Only one claim, per patient, can be submitted per Arbitration Request; however, multiple CPT or HCPCS codes can be disputed on a single claim. For plans that elect to participate in provisions of NRS 439B.700 to 439B.760, only dates of service that fall on or after the third party participation effective date are eligible for arbitration.

This field helps the Third Party to identify the claim.

SINGLE CLAIM INFORMATION:

Claim Date(s) of Service:	**Claim Number:**	**Insured's ID Number:**	**Patient Account Number:**
Total Amount Billed for Claim:	**Total Allowed Amount for Claim:**	**Date Initial Payment Received for Claim:**	
Date Provider/Facility requested additional payment from the Third Party:	**Total additional amount requested by Provider/Facility for Claim:**		

Enter the total amount billed for the **entire claim**, inclusive of all lines on the claim.

This amount must be under $5,000.

Enter the total amount Third Party has allowed for the **entire claim**.

Enter the date **Initial** payment for the claim was received from the Third Party.

Description of Dispute (Use additional pages if necessary):

The Description of Dispute should be **as detailed as possible**. The Out-of-Network Provider/Facility may submit additional pages/documentation with this application to provide rationale that supports the request for additional payment.

SPECIFIC CPT or HCPCS CODE INFORMATION:

Please provide the following information for each CPT or HCPCS code the Provider/Facility would like to dispute on the single claim referenced above:

CPT or HCPCS Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance, or Deductible:	Additional Amount Requested:
.	.	.	.	.	.

Example:

These fields are specific to **each code** the Provider/Facility wishes to dispute on the claim.

All fields must be completed for each code entered.

CPT or HCPC Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance or Deductible:	Additional Amount Requested:
99283		$1784.00	$380.56	$250.00	$921.10
80307	59	$2415.00	$603.75	$603.75	$1086.75

In addition to this application form, Out-of-Network Providers/Facilities MUST submit documentation providing proof of the following:

Acceptable documents may include but are not limited to: corresponding dates, official addresses to and from, information pertaining to the claim.

Emails/Digital correspondence is acceptable.

1. The date on which the Out-of-Network Provider/Facility received initial payment from the Third Party and the amount of payment received;

2. The date on which the Out-of-Network Provider/Facility requested additional amount to be paid by the Third Party and the additional amount requested;

3. Provide the date the Third Party refused to pay the additional amount requested, **OR** if the Third Party failed to pay the additional amount, check the box below:

If the Third Party notified the Provider of refusal to pay, enter the date on which the refusal was received.

OR

Date Third Party Notified Provider of Refusal to Pay: _____

No response received from Third Party ☐

If the Third Party failed to respond to the request to pay the additional amount not later than 30 business days from the date the Provider /Facility submitted the request, check the box.

If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the hospital, person, or health care services, included in the request, are inapplicable to the provisions of NRS 439B.745 and 439B.748, the request for arbitration will be denied.

Pursuant to NRS 439B.742, the provisions of NRS 439B.745 and 439B.748 do not apply to:

1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;
2. A person who is covered by a policy of health insurance that was sold outside this State; or
3. Any health care services provided more than 24 hours after notification is provided pursuant to NRS 439B.745 that a person has been stabilized.

_____

Provider/Facility Name or Designee (please print)

_____ _____

Signature **Date**

Return the completed application and supporting documentation to:

Office for Consumer Health Assistance
Attn: Consumer Health Advocacy Specialist
3320 W. Sahara Ave., Suite 100
Las Vegas, Nevada 89102

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

For any questions or assistance, contact the **Office for Consumer Health Assistance at (702) 486-3587** or toll free at **(888) 333-1597**.