STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
Bureau for Hospital Patients
555 E. Washington Avenue, Suite 4800 | Las Vegas, Nevada 89101
Phone: (702) 486-3587 | Toll Free (888) 333-1597
Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

FOR OFFICE USE ONLY

OCHA CASE # _____

RECEIVED BY: _____

DATE: _____

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 calendar 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** ☐ **Out-of-Network Facility**

Provider/Facility Name:	**Provider/Facility DBA:**
Provider Type and Specialty:	**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):**

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 Party Name:	**Third Party Type:**
Third Party Contact Name:	**Third Party Contact Mailing Address:**
Third Party Contact Phone:	
Third Party Contact Email Address:	

DISPUTE INFORMATION

Only one claim, per patient, per date of service, can be submitted per Arbitration Request; however, multiple CPT codes can be disputed on a single claim.

SINGLE CLAIM INFORMATION:

Claim Date of Service:	**Date Initial Payment Received for Claim:**	**Total Payment Amount for Claim:**
Date request for additional payment was sent to Third Party:	**Total additional amount requested by Provider/Facility for Claim:**	
Description of Dispute (Use additional pages if necessary):		

SPECIFIC CPT CODE INFORMATION:

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

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

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

1. The date on which the Out-of-Network Provider/Facility received 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. 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:

☐ No response received from Third Party

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
555 E. Washington, Ste 4800
Las Vegas, Nevada 89101

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**.