STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
Bureau of 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 # _____

OMBUDSMAN: _____

SCANNED: ☐ **BY:** _____ **DATE:** _____

REQUEST FOR ASSISTANCE

PLEASE NOTE - THIS OFFICE DOES NOT PROVIDE FINANCIAL ASSISTANCE

PLEASE READ CAREFULLY - Before you file a Request for Assistance with the Office for Consumer Health Assistance (OCHA), Bureau for Hospital Patients, you should first contact your health insurance company/hospital, to try to resolve the issue(s). If you don't receive a satisfactory response, then complete this form, and sign the attached "Consent/Authorization for Use and Disclosure of Protected Health Information" form, and submit to the address on this form. Attach copies of any documents that relate to your Request for Assistance. **I understand that a copy of this Request for Assistance form may be provided to the health plan/worker's compensation plan, or other entities, as needed.**

IT IS THE POLICY OF OCHA TO WITHDRAW FROM PROVIDING ADVOCACY SERVICES IF THE CONSUMER IS REPRESENTED BY AN ATTORNEY. WE MAY STILL BE ABLE TO PROVIDE INFORMATION/EDUCATION WITH RESPECT TO YOUR ISSUE BUT WE CANNOT PROVIDE ADVICE, NOR PROVIDE ADVOCACY SERVICES.

Are you currently represented by an attorney for this issue? ☐ **YES** ☐ **NO**

Is a lawsuit currently on-going or pending? ☐ **YES** ☐ **NO**

NAME OF CONSUMER/PATIENT REQUIRING ASSISTANCE
_____ SOCIAL SECURITY # _____-_____-_____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

PRIMARY PHONE # _____ ALTERNATE PHONE # _____

E-MAIL _____ DATE OF BIRTH _____/_____/_____

AGE _____ GENDER _____ RACE_____ MARITAL STATUS _____

NUMBER OF DEPENDENTS _____ EMPLOYMENT STATUS (PLEASE CIRCLE) EMPLOYED ☐ UNEMPLOYED ☐

FULL-TIME ☐ PART-TIME ☐ INCOME SOURCE(S) ☐ WAGES ☐ SOCIAL SECURITY ☐ PENSION

MONTHLY INCOME $_____ ☐ UNEMPLOYMENT ☐ OTHER _____

HOW MANY PEOPLE IN YOUR HOUSEHOLD DOES THIS INCOME SUPPORT? _____

DO YOU CURRENTLY HAVE A HEALTH CONDITION? YES _____ NO

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IF YOU WERE REFERRED BY A STATE OR FEDERAL AGENCY, WHICH AGENCY? _____

ARE YOU A VETERAN? YES NO

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CONSUMER DATE OF BIRTH: _____

CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CONFIDENTIAL INFORMATION

I, _____, authorize the release of any protected information and/or confidential
(please print your name)
health information from my health plan (Insurer), physician, hospital, third party administrator, utilization management company or any other health care provider or entity related in any way to my "Request for Assistance" to be released to the *State of Nevada Department of Health and Human Services, Office for Consumer Health Assistance (OCHA), Bureau for Hospital Patients.* Further, I authorize the OCHA to release such information as it may deem necessary to resolve the issue(s) described in my "Request for Assistance" including, but not limited to, releasing such information to other government agencies, health care providers, representatives of my insurer, health care or insurance experts, or others.

I realize this is a required consent and I voluntarily sign this authorization before any parties to this matter can discuss any information pertaining to my case. This Consent/Authorization for Use and Disclosure of Protected Health Information - Confidential Information waives any, and all, rights I may have now or in the future to bring any legal action against OCHA or the releasing person or facility, for any damages caused directly or indirectly by the release of said information. *I further understand that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).*

I understand that this authorization is effective immediately and that I may revoke this authorization within five (5) days by written notice to OCHA and my health plan (insurer), physician, hospital, third party administrator, utilization management company or any other health care provider or entity. Exception to this right is if action has already been taken as a result of this authorization.

*****THIS RELEASE IS EFFECTIVE FOR ONE YEAR FROM THE SIGNATURE DATE.*****
This authorization expires on: _____/_____/_____
(ONE YEAR FROM signature date)

I further understand that I may inspect or copy the information used or disclosed.

I authorize OCHA to speak with my designated representative below (Family member, friend, legal representative) about my case:

_____ _____ _____
Printed name of Designated Representative Personal Representative's Signature Relationship

Personal/Designated Representative's phone number: _____

X_____ _____
Signature of Consumer or *Legal Representative ***Signature Date***

**Attach documentation of legal representation – required upon submission of form.*

CIRCLE AND COMPLETE THE CATEGORY THAT BEST DESCRIBES YOUR ISSUE:

Workers' Compensation	Date of Injury _____ Body part _____ Workers' Compensation Insurer/Third Party Administrator_____ Phone #_____ Claim # _____ Name of Employer_____
Medicare/ Medicaid	Medicare/Medicaid ID #_____ Do you have a Medicare Advantage Plan? (Ex: Aetna, AARP, Humana) YES NO Don't Know Name of Medicare Advantage Plan: _____ Phone #_____
Health Insurance	Insurance Company _____ Phone #_____ Policy/Group# _____ ID#_____ Have you contacted the Insurer? YES NO Contact Name_____
Hospital Billing	Name of Hospital:_____ Phone # _____ **(Please attach a copy of all hospital bills)**
Physician Billing	Name of physician/provider of healthcare services _____ Phone # _____ **(Please attach a copy of all medical bills)**
Uninsured	How long have you been uninsured? ____Year(s) ____ Month(s) Have you accessed City, County, State or Federal resources, to date? YES NO If "YES" which one(s) _____ Are you a resident of Nevada eligible to purchase health insurance? YES NO

PLEASE DESCRIBE YOUR ISSUE/CONCERN: (ADD ADDITIONAL PAGES IF NECESSARY)

_____

_____

_____

_____

WHAT WOULD YOU CONSIDER TO BE A FAIR RESOLUTION TO YOUR ISSUE/CONCERN?

_____

_____

_____

_____

I certify to the best of my knowledge that the information furnished herein is true and correct.

X_____ _____

Signature of Consumer or *Legal Representative ***Date***

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APPOINTMENT OF OCHA AS AUTHORIZED REPRESENTATIVE

(Complete this form **ONLY** if you are insured.)

NAME _____ **OCHA CASE #** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

PRIMARY PHONE # _____ **ALTERNATE PHONE #** _____

NAME OF HEALTH PLAN _____ **PHONE #**_____ **CLAIM #**_____

POLICY/GROUP ID #_____ **MEMBER ID#**_____

I, hereby, appoint the ***State of Nevada Department of Health and Human Services, Office for Consumer Health Assistance (OCHA), Bureau for Hospital Patients*** *to act as my representative in requesting a reconsideration of a coverage/claim denial made by the aforementioned health plan. I authorize OCHA to make the appeal request, present or elicit evidence, to obtain appeals information, and to receive any notice in connection with my appeal. I understand that personal medical information related to my appeal may be disclosed to this person. NRS223.500*

Signature of Consumer **Date**

X_____ _____

Signature of Consumer **Date**

FOR OFFICE USE ONLY

Appointed Representative **Above appointment accepted by OCHA?** YES NO

Signature of Appointed OCHA Representative **Date**