

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: <u>cha@govcha.nv.gov</u>

FOR OFFICE USE ONLY		
OCHA CASE #		
ARBITRATOR:		
RECEIVED: BY: DATE:		

## REQUEST FOR ARBITRATION CLAIMS UNDER \$5,000

An out-of-network provider requesting arbitration for claims of medically necessary emergency services must submit an application in the format specified below. The request must be submitted within 30 days from the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec 17.3. The Department of Health and Human Services will not accept applications requesting arbitration past 30 business days from the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec 17.3 and payment received will be considered payment in full.

Provider type for which arbitration application is being submitted:

Out-of-Network Provider
Out-of-Network Emergency Facility

Provider/ Facility Name:	Provider/ Facility DBA:
Provider Mailing Address:	Provider Physical Address:
Provider Phone:	Provider Specialty:
Provider Fax:	Provider Email:
Has Provider ever contracted with Third Party?  Yes	If yes, date contract terminated (month/ year):
No	
Provider/ Facility Contact Name:	Contact Phone:
Third Party Name:	Third Party Type:

Third Party Physical Address:		Third Party Mailing Address:	
Third Party Phone:		Date of Service:	
Date request for additional payment was sent to Third party:		Additional amount requested from Provider:	
CPT code(s) billed:		CPT modifier billed (if any):	
Original Claim Billed Amount:	Original Claim	Paid Amount:	Date Original Claim Paid:
Description of Dispute (Use addit	ional pages if r	necessary):	
Desired outcome:			

Supporting documents to include with this application:

- Date out-of-network provider received payment by the third party
- Amount of payment received
- Date out-of-network provider requested additional amount to be paid by the third party
- Additional amount requested by the out-of-network provider

•	A representative sample of at least 3 fees received by the provider in the last 24 months for the
	same service, in the same region, from health plans in which the provider does not participate.
	If provider does not have at least three representative samples, provide explanation:

I attest that the information provided in this application is true and accurate to the best of knowledge.			
Provider Name (please print)			
Signature	Date		

Please 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 to: (702) 486-3586 | Email: CHA@govcha.nv.gov

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