



STATE OF NEVADA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
 Bureau for Hospital Patients
 3320 W. Sahara Ave, Suite 100 | Las Vegas, Nevada 89102
 Phone: (702) 486-3587 | Toll Free (888) 333-1597
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<u>FOR OFFICE USE ONLY</u>
RECEIVED BY: _____
DATE: _____

NRS 687B.675 (1)(b) Health Carrier Annual Reporting Form

Pursuant to NRS 687B.675 (1)(b), on or before December 31 of each year, a health carrier which offers or issues a network plan shall submit to the Office for Consumer Health Assistance, for the immediately preceding 12 months, for each type of provider of health care in the applicable network: (1) The number of times covered persons reported difficulty accessing health care services; (2) The number of times covered persons used a navigator, case manager or facilitator to assist in accessing health care services; (3) The number of cases described in subparagraph (2) that were resolved by navigators, case managers or facilitators; and (4) The average period between when a covered person reports difficulty accessing health care services to the resolution of the case by a navigator, case manager or facilitator.

Health Carrier Name:	DBA (if applicable):	Contact Person:
Contact Phone:	Contact Email:	Contact Fax:

Column 1	Column 2	Column 3	Column 4	Column 5
Enter type of provider of health care	Enter the number of times covered persons reported difficulty accessing health care services from the type of provider of health care entered in column 1	Enter number of times covered persons used a navigator, case manager or facilitator to assist in accessing health care services from the type of provider of health care entered in column 1	Out of the number of cases provided in column 3, enter the number of cases that were resolved by navigators, case managers or facilitators	Enter the average period (average number of days) between when a covered person reports difficulty accessing health care services to the resolution of the case by a navigator, case manager or facilitator

If more lines are needed to enter additional types of providers of health care, please submit an additional form.

_____	_____
Health Carrier Designee (please print)	Title
_____	_____
Signature	Date

Submit form to: Office for Consumer Health Assistance Attn: Consumer Health Advocacy Specialist 3320 W. Sahara Avenue, Suite 100 Las Vegas, Nevada 89102 This document 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 .
