State of Nevada
Department of Health and Human Services
Aging and Disability Services Division
Office for Consumer Health Assistance
Bureau for Hospital Patients
3320 W. Sahara Avenue, Suite 100 | Las Vegas, Nevada
89102 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 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):**

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.

Third Party Name:	**Third Party Type:** Selection Required*
Third Party Arbitration Contact Name:	**Third Party Arbitration Contact Mailing Address:**
Third Party Arbitration Contact Phone/ Fax:	
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.

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:**		
Description of Dispute (Use additional pages if necessary):			

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:
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(Continued) SPECIFIC CPT or HCPCS CODE INFORMATION:

Please provide the following information for each additional 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:

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. 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:

   Date Third Party Notified Provider of Refusal to Pay ☐

   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.700 and 439B.760, the request for arbitration will be denied.

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NRS 439B.742, inapplicability of provisions to certain hospitals, persons and healthcare services:

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.

Arbitration costs:

Pursuant to NRS 439B.754(7), If the arbitrator requires:

(a) The out-of-network provider to accept the amount paid by the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the out-of-network provider must pay the costs of the arbitrator.

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2, the third party must pay the costs of the arbitrator.

By signing the request for arbitration, I attest:

1. I have verified the third party:

- Is an issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary services; or
- The Public Employees Benefits Program established pursuant to subsection 1 of NRS 287.043; or
- Is an entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.600, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The health insurance policy for the covered person was sold in the state of Nevada, NRS 439B.742(2)**.**

_____

Provider/Facility Name or Designee (please print)

_____ _____

Signature **Date**

Return the completed application and supporting documentation to:

Office for Consumer Health Assistance
Attn: Arbitration Chief
3320 W. Sahara, Ste 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**.