STATE OF NEVADA

OFFICE OF THE GOVERNOR

CONSUMER HEALTH ASSISTANCE

BUREAU FOR HOSPITAL PATIENTS

555 E. Washington Avenue Ste 4800
Las Vegas, NV 89101
(702) 486-3587 1-888-333-1597 (toll free)
www.govcha.state.nv.us
Email: cha@govcha.state.nv.us

REQUEST FOR ASSISTANCE

Please fill out this assistance form as accurately and completely as possible and return it to the office above.

Name_____ Social Security Number_____

Address_____ Date of Birth_____

City_____ State_____ Zip_____

Phone _____Other Phone _____Email_____

Circle M / F Ethnicity _____ Educational Level _____

Before you file a Request for Assistance with the Office of the Governor for Consumer Health Assistance, Bureau for Hospital Patients, you should first contact your healt insurance company/hospital, in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, and sign the attached "Consent / Authorization for the Use and Disclosure of Protected Health Information – Confidential Information" form, and mail to the address on this form. Attach copies of any pertinent documents that relate to your Request for Assistance.

I understand that a copy of this Request for Assistance may be provided to the health plan / worker's compensation plan, or other entity.

1. Complete name of Health Plan involved with Telephone N ber or write "*Uninsured" :*
   _____
   _____
2. Circle type of Health Plan/Insurance: *Medicare Medicaid Workers Compensation Group Health Plan Other*_____
3. Third Party Administrator's Name and Telephone Number: _____ _____
   _____
4. Broker's Name and Telephone Number (if applicable) _____
5. Policy Identification or Certificate Number: (if applicable _____ _

6. Employer (if applicable: _____

7. Claim Number (if applicable):_____

8. Have you contacted the Health Plan? Yes_____ No_____ (if applicable)

   Date: _____Person:_____Phone no.:_____

   _____

   (**Provide copies of all correspondence-denial letters**)

9. Who or what agency or office referred you to Consumer Assistance / Bureau for HospitalPatients?_____ _____

10. Is there attorney representation in this matter? Yes_____ No_____

11. Is a lawsuit currently on-going or pending? Yes_____ No_____

12. Describe your concern / issue. If the issue relates to a hospital bill(s), please list hospital name, date(s) of service, type of service (inpatient or outpatient), patient account number, reason for hospitalization (use additional paper if needed):

_____

_____

_____ _____

13. What do you consider to be a fair resolution to your concern / issue?

_____

_____ _____

_____

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

_____ _____

Signature Date

THANK YOU. PLEASE REMEMBER TO ATTACH ALL PERTINENT DO IF YOU SHOULD HAVE ANY QUESTIONS, YOU MAY CALL ONE OF THE NUMBERS LISTED ON THIS FORM.

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CONSENT / AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - CONFIDENTIAL INFORMATION

I, _____, authorize the release of any protected health
(consumer name)
information/confidential information from my **Health plan (Insurer), Physician, Hospital, Third Party Administrator, Utilization Management Company or any other Health Care Provider / entity** related in any way to my "Request for Assistance" to be released to the *Office of the Governor, Consumer Health Assistance/Bureau for Hospital Patients.* Further, I authorize the "Office" to release such information as it may deem necessary to resolve my "Request for Assistance" filed with that office 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 understand that this authorization is effective immediately and I may revoke this authorization on 5 days written notice to the "Office" and my health plan (insurer), physician, hospital, third party administrator, utilization management company or any other health care provider/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.**

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 the "Office", the releasing person or facility for any damages caused directly or indirectly the release of said information. *I further understand that information disclosed pursuant to this authorization is subject to redisclosure by the recipient and is no longer protected under the Health Insurance Portability and Accountability Act of 1996.*

_____ _____
Consumer Signature Date

STATE OF NEVADA

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE

NAME:	HEALTH PLAN:
ADDRESS:	INSURANCE ID#:
CITY: STATE: ZIP:	PHONE NO: (AREA CODE)

FILE NO._____

I appoint the Governor's Office for Consumer Health Assistance, Bureau for Hospital Patients to act as my representative in requesting a reconsideration of a coverage / claim denial made by the above referenced health plan. I authorize this son (GovCHA) 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

CONSUMER SIGNATURE:	*DATE:*
APPOINTED REPRESENTATIVE:	*Accept the above appointment:* *Yes NO (circle one)*
SIGNATURE OF APPOINTED GOVCHA REPRESENTATIVE:	*DATE:*

Comment or added information: