



STATE OF NEVADA  
**OFFICE OF CONSUMER HEALTH ASSISTANCE**  
 BUREAU FOR HOSPITAL PATIENTS  
 OFFICE OF MINORITY HEALTH  
 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101  
 (702) 486-3587 – Toll Free (888) 333-1597 – Fax (702) 486-3586  
 www.govcha.state.nv.us E-mail: cha@govcha.state.nv.us

FOR OFFICE USE ONLY	
GOVCHA CASE # _____	
CCIO CASE # _____	
SCANNED: <input type="checkbox"/>	BY: _____ QAS: _____

## REQUEST FOR ASSISTANCE

**PLEASE NOTE - THIS OFFICE DOES NOT PROVIDE FINANCIAL ASSISTANCE**

NAME _____		SOCIAL SECURITY #. _____	
ADDRESS _____	CITY _____	STATE _____	ZIP CODE _____
PRIMARY PHONE # _____		ALTERNATE PHONE # _____	
E-MAIL _____		DATE OF BIRTH _____	
HOW DID YOU HEAR ABOUT THIS OFFICE? _____			
IF YOU WERE REFERRED BY A STATE OR FEDERAL AGENCY, WHICH AGENCY? _____			

*The demographic questions below provide the Federal Government with information to improve services.*

AGE _____	GENDER _____	MARITAL STATUS _____	EMPLOYMENT STATUS _____
SIZE OF EMPLOYER _____	SPOUSE'S EMPLOYMENT STATUS _____	SIZE OF SPOUSE'S EMPLOYER _____	SELF-EMPLOYED? _____
HEALTH CONDITION? _____ IF "YES", SPECIFY CONDITION _____			
INCOME SOURCE _____		MONTHLY INCOME \$ _____	HAS THERE BEEN A CHANGE IN YOUR INCOME IN THE PAST YEAR? _____
HOW MANY PEOPLE DOES YOUR INCOME SUPPORT? _____		ARE YOU A VETERAN? _____	

*Before you file a Request for Assistance with the State of Nevada Office of Consumer Health Assistance ("CHA"), Bureau for Hospital Patients, Office of Minority Health, you should first contact your health 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 form may be provided to the health plan/worker's compensation plan, or other entity.*

Circle the type of health plan: <b>MEDICARE</b> <b>MEDICAID</b> <b>WORKER'S COMPENSATION</b> <b>GROUP HEALTH PLAN</b>
Name of insurance company involved _____ Phone # _____
(If uninsured, enter "Uninsured") _____ OTHER (please specify) _____
Policy/Group# _____ ID# _____
Name and phone number of Third Party Administrator (TPA) _____
Have you contacted the health plan? YES _____ NO _____ If "YES", what was the date? _____
Who did you speak with? _____ Phone # _____
Claim # _____ Employer's Name and Phone Number (if applicable) _____



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IT IS THE POLICY OF THE OFFICE OF CONSUMER HEALTH ASSISTANCE 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 MAY NOT PROVIDE ADVICE, LEGAL OR OTHERWISE.

Are you currently represented by an attorney for this issue? YES \_\_\_\_\_ NO \_\_\_\_\_

Is a lawsuit currently on-going or pending? YES \_\_\_\_\_ NO \_\_\_\_\_

PLEASE DESCRIBE YOUR ISSUE/CONCERN

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.*

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

**THANK YOU. PLEASE REMEMBER TO ATTACH ALL PERTINENT DOCUMENTS.**

If you have any questions, please call one of the numbers listed at the top of 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 information and/or  
 (please print your name)  
 confidential health 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 State of Nevada Office of Consumer Health Assistance (“CHA”)/Bureau for Hospital Patients/Office of Minority Health. Further, I authorize the “CHA” to release such information as it may deem necessary to resolve 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 understand that this authorization is effective immediately and that I may revoke this authorization within 5 days by written notice to “CHA” 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 further understand that I may inspect or copy the information used or disclosed.

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 “CHA” 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.*

This authorization expires on: \_\_\_\_\_  
 (one year from signature date)

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Consumer or  
 Personal Representative

\_\_\_\_\_  
 Relationship to Consumer or Authority to  
 act on Their Behalf



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**APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

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

NAME _____		CHA 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 Office of Consumer Health Assistance (“CHA”), Bureau for Hospital Patients, Office of Minority Health** to act as my representative in requesting a reconsideration of a coverage/claim denial made by the aforementioned health plan. I authorize “CHA” 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Appointed Representative

Above appointment accepted by CHA? YES NO

\_\_\_\_\_  
Signature of Appointed CHA Representative

\_\_\_\_\_  
Date