

## REQUEST FOR HEARING

### CLAIMANT INFORMATION

Claimant:
Address:
Telephone:

### EMPLOYER INFORMATION

Claim number:
Employer:
Address:
Telephone:

PERSON REQUESTING APPEAL: (circle one) CLAIMANT EMPLOYER INSURER

I WISH TO APPEAL THE DETERMINATION DATED: \_\_\_\_\_

***YOU MUST ATTACH A COPY OF THE DETERMINATION LETTER PER  
NRS 616C.315 2(a)(b)***

**PLEASE CHECK HERE IF YOUR REQUEST IS REGARDING  
A CLAIM FILED PURSUANT TO NRS 617.455 OR 617.457**

BRIEFLY EXPLAIN REASON FOR APPEAL:

If you are represented by an attorney or other agent, please print the name and address below.

### ATTORNEY/REPRESENTATIVE:

Name:
Address:
Telephone:

### INSURANCE COMPANY:

Name:
Address:
Telephone:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**A COPY OF THE DETERMINATION LETTER MUST BE SUBMITTED:**

**NRS 616C.315 Request for hearing; forms for request to be provided by Insurer; appeals; expeditious and informal hearing required; direct submission to Appeals Officer.**

2. Except as otherwise provided in NRS 616C.305, a person who is aggrieved by:

- (a) A written determination of an Insurer; or
- (b) The failure of an Insurer to respond within 30 days to a written request mailed to the Insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a Hearing Officer.....