

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)**

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.....