STATE OF NEVADA
**GOVERNOR'S CONSUMER HEALTH ADVOCATE**
**OFFICE FOR 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.nv.gov E-mail: cha@govcha.nv.gov

**FOR OFFICE USE ONLY**
GovCHA CASE # ____________________
CCIIO CASE #____________________
SCANNED: ☐ BY: _______ QAS: _______

# REQUEST FOR ASSISTANCE

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

**PLEASE READ CAREFULLY** - *Before you file a Request for Assistance with the State of Nevada Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA"), 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,***

**IT IS THE POLICY OF GovCHA 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 WE CANNOT PROVIDE ADVICE, OR ADVOCACY SERVICES.**

**Are you currently represented by an attorney for this issue?** **YES**_________ **NO**__________

**Is a lawsuit currently on-going or pending?** **YES**_________ **NO**__________

NAME ____________________________________ SOCIAL SECURITY # (LAST FOUR) XXX-XX-__________

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

AGE _____ GENDER ____ ETHNICITY _______________ EDUCATION LEVEL ___________________ MARITAL STATUS ________

EMPLOYMENT STATUS ___________ NAME OF EMPLOYER ______________________________ SIZE OF EMPLOYER (SM, MED., LG) ____________

SPOUSE'S EMPLOYMENT STATUS ___________________ SIZE OF SPOUSE'S EMPLOYER (SM, MED, LG) _______________ SELF-EMPLOYED? YES_____ NO _____

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? ________________________

**CIRCLE AND COMPLETE THE CATEGORY THAT BEST DESCRIBES YOUR ISSUE:**

| Category | Details |
|---|---|
| **Workers' Compensation** | Date of Injury:__________________________ Body part: ________________________________<br>Insurer/Third Party Administrator: ____________________________________________________<br>Contact #:______________________________ Claim #: _________________________________<br>Name of Employer: _________________________________________________________________ |
| **Medicare/ Medicaid** | Medicare/Medicaid ID #_________________________<br>Medicare Advantage Plan (Ex: Senior Dimensions, Humana) YES _____ NO_____ Don't Know____<br>Name of Medicare Advantage Plan: ______________________________________________________ |
| **Insurance** | Insurance Company: ___________________________________ Phone #______________________<br>Policy/Group# _______________________________ ID#____________________________________<br>Have you contacted the Insurer? ___Yes ___No Contact Name:____________________________ |
| **Hospital Billing** | Name of Hospital:____________________________________________________________________<br>Phone # ___________________________________________________________________________<br>**(Please attach a copy of all bills(s))** |
| **Physician Billing** | Name of physician/provider of healthcare services:___________________________________<br>Phone # ______________________________________________________________________<br>**(Please attach a copy of all bill(s))** |
| **Uninsured** | How long have you been uninsured? ____Year(s) ____ Month(s)<br>Have you utilized any City, County, or State resources, to date? YES ___ NO___<br>If "YES" which one(s): ________________________________________________________________ |
| Other (please specify below) | |

**PLEASE DESCRIBE YOUR ISSUE/CONCERN: (ADD ADDITIONAL PAGES IF NECESSARY)**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**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 of Consumer or Legal Representative ***** Date

****Documentation of legal representation required***

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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 or entity** related in any way to my "Request for Assistance" to be released to the *State of Nevada Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA").* Further, I authorize the GovCHA 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 five (5) days by written notice to GovCHA and my health plan (insurer), physician, hospital, third party administrator, utilization management company or any other health care provider or 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 GovCHA 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)

I AUTHORIZE GovCHA TO SPEAK WITH MY DESIGNATED REPRESENTATIVE BELOW *(Family Member, Friend, Legal Representative)* ABOUT MY CASE:

| ________________________________ | ________________________________ | ________________________ |
|---|---|---|
| Printed name of Designated Representative | Personal Representative's Signature | Relationship |

Personal/Designated Representative's phone number: ____________________________________________

| ________________________________ | ________________________________ |
|---|---|
| Signature of Consumer | Date |

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# APPOINTMENT OF GovCHA AS AUTHORIZED REPRESENTATIVE

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

**NAME** ________________________________ **GovCHA 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 Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA")** to act as my representative in requesting a reconsideration of a coverage/claim denial made by the aforementioned health plan. I authorize 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*

________________________ ________________________
**Signature of Consumer** **Date**

**FOR OFFICE USE ONLY**

________________________
**Appointed Representative** **Above appointment accepted by GovCHA? YES NO**

________________________ ________________________
**Signature of Appointed GovCHA Representative** **Date**