

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO: Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-8440

OR Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

Employee Information	
Employee's Name and Address	
Employee's Telephone Number	Claim No.
	Date of Injury
Insurer Information	
Insurer's Name and Address	
Insurer's Telephone Number	

Employer Information
Employer's Name and Address
Employer's Telephone Number
Third-Party Administrator Information
Third-Party Administrator's Name and Address
Third-Party Administrator's Telephone Number

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination.

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

The Injured Employee

This request for hearing is filed by, or on behalf of: **The Employer**

and is dated this _____ day of _____, 20_____.

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)