TO:

RE: Claim No: _____

Employer: _____

Insurer: _____

TPA: _____

Date of Injury: _____

Date of Notice: _____

Body Part: _____

NOTICE OF CLAIM ACCEPTANCE
(Pursuant to NRS 616C.065)

Dear

The above referenced claim has been accepted on your behalf by (Insert Insurer Name). Please check the information contained on this notice. If you find any of the information to be incorrect, please notify the insurer handling the claim.

If you disagree with the above determination, you do have the right to appeal by requesting a hearing before a Hearing Officer by completing the bottom portion of this notice and sending it to the State of Nevada, Department of Administration, Hearings Division. **Your appeal must be filed within seventy (70) days after the date on which the notice of this determination was mailed.**

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89710
(775) 687-8440

OR

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

Very truly yours,

Reason for appeal: _____

_____

_____

_____

_____ _____

Signature Date

Retain a copy for your records

c.:

Enclosure