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

D-30 (rev. 5/10)