<Date>

<Addressee>

Re: Claim Number:
Date of Injury:
Employer:
Insurer:
Claims Administrator/Third-Party Administrator:
Body Part(s)/Diagnosis:

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

Dear >

The above referenced claim has been accepted on behalf of (**Insert Insurer**). Please check the information contained in this notice. If you find any of the information to be incorrect, please notify the claims administrator who is handling this 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 enclosed Form D-12a 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 89701
(775) 687-8440

OR

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

If you have any questions, please contact >

Sincerely,

<Claims Adjuster>

Enclosure: D-53, D-12a >

cc:

Please retain a copy for your records

<If established and available, internet address for the website to obtain a list of healthcare providers>