# 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:

_____

_____

_____

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

**The Injured Employee**

**The Employer**

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

_____ _____

Signature of Injured Employee/Employer

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