

POC FORM AND ACCOMPANYING INSTRUCTIONS

For Internal Office Use Only: POC # _____, Claim Type: _____, Date Received: _____

Claimant Name & Address	Policy Information (if applicable)
Name	Insured Name
Date of Birth SSN	Insured DOB
Company Name and Tax ID (if applicable)	Member ID
Street Address	Coverage Date(s)
City/State/Zip	Alternate Contact Name & Telephone No.
Phone E-Mail	
If Claimant is represented by an attorney, please complete this section and attach copy of Power of Attorney	
Name of Attorney & Attorney's Firm	Bar Card No.
Street Address	Tax ID No.
City/State/Zip	Ph.
E-mail Address	Fax

All claims submitted to the Special Deputy Receiver ("SDR") shall set forth in reasonable detail: (1) the amount of each of the claims; (2) the facts and basis upon which each of the claims and claim amounts is based; and (3) the priority level for the claims being submitted to the SDR (*i.e.*, "priorities" mean a secured creditor claim, a policyholder claim, an unsecured general creditor claim, etc.). All such claims must be verified by the claimant's affidavit, or someone authorized to act on behalf of the claimant and having knowledge of the facts (and must include adequate documentation). All claims and documentation supportive of each of the claims should be submitted to the SDR. The SDR reserves the right to request additional documentation, as needed, to make a determination of your claim. Health Care Providers ("Providers"), such as physicians or hospitals, are exempt from using this POC form for existing claims that they have already filed with NHC or new claims that they may file. Providers should not submit the POC form for their claims, but should closely review the POC Instructions for detailed guidance regarding deadlines and submission requirements for Provider claims. See the pages that follow for the POC Instructions to use when completing this POC form and for information about Provider claims.

Explanation of Claim:	(Attach additional pages if necessary)
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State of _____ §
 §
 County of _____ §

Unless otherwise expressly noted in this Proof of Claim Form, I alone am entitled to file this Proof of Claim Form, no others have an interest in the claims being submitted through this Proof of Claim Form, no payments have been made on the claim or claims herein submitted, no third party is liable on this debt, the sums claimed in this Proof of Claim Form are justly owing, and there is no set-off or other defense to the payment of this claim. I declare, under penalty of perjury, that all of the statements made in this Proof of Claim Form and all the documents attached to this form are true, complete, and correct.

 Signature of Claimant or Authorized Agent

 Printed Name

Sworn to and subscribed before me this _____ day of _____ 20_____.

 Notary Public Signature

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM.

PROOF OF CLAIM INSTRUCTIONS

READ CAREFULLY BEFORE COMPLETING THE PROOF OF CLAIM FORM

Use this Proof of Claim (“**POC**”) form to make your claim against the receivership estate of Nevada Health CO-OP (“**NHC**”). By accurately completing this form, you make your claim for payment and help the Special Deputy Receiver (“**SDR**”) properly consider your claim. *It is very important that you complete all the sections applicable to you, and sign and return the form to the SDR as provided below. Forms that are incomplete or inaccurate may result in a delay or denial of your claim.* The SDR will review your claim and determine whether you are entitled to any claim payment.

A POC FORM MUST BE COMPLETED, SIGNED, AND RECEIVED BY NHC ON OR BEFORE APRIL 28, 2017 (THE “CLAIMS DEADLINE”). ANY POC SENT BY U.S. MAIL WILL BE DEEMED TIMELY FILED SO LONG AS IT IS RECEIVED WITHIN THREE BUSINESS DAYS AFTER THE CLAIMS DEADLINE. FAILURE TO TIMELY FILE YOUR POC BEFORE THE CLAIMS DEADLINE WILL CAUSE YOUR CLAIM TO BE CLASSIFIED AS LATE AND MADE INELIGIBLE FOR A DISTRIBUTION OF ASSETS, IF ANY, FROM NHC. CLAIMS MUST BE NON-CONTINGENT AND LIQUIDATED IN AMOUNT BY THE DEADLINE TO SHARE IN NHC’S ASSETS.

To complete this form, please follow these instructions:

Provide your full name, permanent address, telephone number, and (if you have e-mail access) your e-mail address. You must notify the SDR in writing of any change in mailing address or telephone number that occurs during the receivership.

1. The “Claimant” is the person/entity believed to be owed money by NHC. You must provide the Claimant’s name and Social Security number and/or Tax ID number on the POC form. The POC form must also be signed and dated. Claims filed by business organizations must be signed by an authorized representative, and the capacity of the signatory must be stated on the claim form. A power of attorney must be attached if an attorney is signing this form on behalf of a client.

Health Care Providers (“Providers”), such as physicians or hospitals, are exempt from being required to use the POC form for existing claims that they already have filed with NHC or new claims that they may file. Providers are not required to re-file existing claims with NHC, and these existing claims will be considered timely filed so long as they comply with the pre-established procedures for processing claims in the normal course of business of NHC (*e.g.*, in most cases, claims filed for the first time more than 12 months after the date of service are considered late-filed claims by NHC and may be denied by the SDR for this reason). New claims of Providers must be filed with NHC by the Claims Deadline, but the claims for healthcare services must be submitted as they have previously been to NHC, and will still be subject to all pre-established NHC claim processing requirements and deadlines. Providers should not use this POC form for the submission of new claims. New Provider claims filed after the Claims Deadline will be considered late-filed claims and are ineligible for payment. PROVIDERS SHOULD NOT SUBMIT DUPLICATE CLAIMS (*i.e.*, claims that have been previously submitted to NHC), as this will delay the processing time for all of their claims. However, you may re-submit claims that require correction. Providers who have received any partial claim payment are not required to submit a POC form for the remaining amount owed—and they are not required to take any further action unless notified by NHC in receivership.

Providers should contact 1-855-606-2667 or e-mail POC@NevadaHealthCoop.org to verify that all their claims have been submitted and are being processed.

PROOF OF CLAIM INSTRUCTIONS

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For all claims other than Providers, new claims must be submitted by the Claims Deadline by using this POC form and following these instructions. Claims received after the Claims Deadline will be considered late-filed claims and ineligible for payment.

2. If you are a **Member** filing your own claims, please note all bills must be itemized showing dates of service and type(s) of service rendered. If you previously assigned your claim to a medical provider, another person or entity, please provide the SDR a copy of the assignment.
3. Claims for healthcare services rendered in 2016 or later should not be submitted to NHC. As announced on August 25, 2015, NHC ceased providing health coverage effective January 1, 2016. All NHC policies were terminated by December 31, 2015.
4. **YOU MUST INCLUDE DOCUMENTATION SUPPORTING YOUR CLAIM.** A claim may be disallowed partially or entirely if it fails to adequately describe or document the claim. All supporting documentation must be submitted to the Receiver of NHC before the Claims Deadline.
5. To reduce expenses to the receivership estate, the SDR will not be sending acknowledgement of receipt of the POC forms. You will, however, receive notice of any decision on your claim at the address you have provided to the SDR on the POC form. If you have a change of address after submitting your POC form, you must update the SDR so that you will continue to receive correspondence regarding your claim. Claimants may contact 1-855-606-2667 or e-mail **POC@NevadaHealthCoop.org** to verify that all their POCs have been received by the SDR.
6. The receivership estate may only pay part of approved claims based on NHC's available assets.
7. If applicable, you must disclose all deposits, cash, premiums, securities, trust funds, letters of credit, or other assets of NHC you hold, control, or expect to receive from anyone other than NHC. Agents or brokers must submit an accounting of all premiums and commissions held at the time plans were terminated.
8. After you complete the POC form, review the completed form, sign in front of a Notary Public, and date. Failure to properly complete the POC form according to these instructions may cause your claim to be delayed or disallowed. It is recommended that you return the POC form using Certified Mail, Return Receipt Requested, or another method providing proof of delivery. Please retain a copy for your records, and submit the form to:

Nevada Health CO-OP
ATTN: Special Deputy Receiver/POC
840 S. Rancho Drive #4-321
Las Vegas, Nevada 89106

You may also submit your POC form by e-mail, to **POC@nevadahealthcoop.org**, so long as the e-mail includes an executed and sworn (*i.e.* signed and notarized) proof of claim. Claimants submitting by e-mail may wish to contact NHC to confirm that their POC form was received, particularly if they have attached large files. Claimants are responsible for assuring that their claims are received by the above deadline!