ASSEMBLY BILL NO. 133–ASSEMBLYMAN MABEY

FEBRUARY 20, 2007

Referred to Committee on Commerce and Labor

SUMMARY—Revises certain provisions relating to the status of policies covering patients for health or dental care. (BDR 57-807)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to insurance; requiring issuers of policies of health or dental insurance to notify providers of health or dental care of the status of policies of health or dental insurance issued to patients of the provider of health or dental care; requiring providers of health or dental care to inform their patients of certain matters after receiving such notification; requiring providers of health or dental care to reimburse their patients for certain costs paid under certain circumstances; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing regulatory law allows a health or dental insurer to refuse to pay claims incurred during the grace period for the payment of the premium for a health or dental insurance policy if the required premium on the policy is not paid. (NAC 687B.630) This bill requires issuers of policies of health or dental insurance to notify providers of health or dental care of the status of health or dental insurance policies issued to patients of the health or dental care provider. This bill also requires providers of health or dental care to inform patients of the possible actions of those providers after receiving such notice. This bill also requires providers of health or dental care who subsequently receive payment from insurers for services that have already been paid for by patients to reimburse the patients to the extent that the insurers make payment for those same provided services.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

**Section 1.** Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from an insurer pursuant to paragraph (c) of subsection 5 of NRS 689A.035:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the insurer a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the insurer for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the insurer, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 2.** NRS 689A.035 is hereby amended to read as follows:

689A.035 1. An insurer shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes

effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

5. ***If a provider of health care requests that an insurer verify whether a patient of the provider of health care is covered by a policy of health insurance, the insurer shall:***

***(a) If the patient is covered by a policy of health insurance issued by the insurer and payment of the premium for the policy has been received by the insurer, notify the provider of health care that the patient is covered by a policy of health insurance issued by the insurer;***

***(b) If the patient is not covered by a policy of health insurance issued by the insurer, notify the provider of health care that the patient is not covered by a policy of health insurance issued by the insurer; or***

***(c) If the patient is covered by a policy of health insurance issued by the insurer, the payment of the premium for the policy has not been received by the insurer and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a policy of health insurance issued by the insurer;***

***(2) The premium on that policy has not been received by the insurer; and***

***(3) If the insurer does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the policy for any claim made during the grace period.***

***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 3.** Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from an insurer pursuant to paragraph (c) of subsection 5 of NRS 689B.015:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the insurer a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the insurer for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the insurer, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 4.** NRS 689B.015 is hereby amended to read as follows:

689B.015 1. An insurer that issues a policy of group health insurance shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

5. ***If a provider of health care requests that an insurer verify whether a patient of the provider of health care is covered by a policy of group health insurance, the insurer shall:***

***(a) If the patient is covered by a policy of group health insurance issued by the insurer and payment of the premium for the policy has been received by the insurer, notify the provider of health care that the patient is covered by a policy of group health insurance issued by the insurer;***

***(b) If the patient is not covered by a policy of group health insurance issued by the insurer, notify the provider of health care that the patient is not covered by a policy of group health insurance issued by the insurer; or***

***(c) If the patient is covered by a policy of group health insurance issued by the insurer, the payment of the premium for the policy has not been received by the insurer and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a policy of group health insurance issued by the insurer;***

***(2) The premium on that policy has not been received by the insurer; and***

***(3) If the insurer does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the policy for any claim made during the grace period.***

***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 5.** Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from a carrier pursuant to paragraph (c) of subsection 5 of NRS 689C.435:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the carrier a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the carrier for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the carrier, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 6.** NRS 689C.435 is hereby amended to read as follows:

689C.435 1. A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the carrier to its insureds.

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the carrier uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a carrier specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the carrier upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a carrier specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the carrier shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

5. ***If a provider of health care requests that a carrier verify whether a patient of the provider of health care is covered by a health benefit plan, the carrier shall:***

***(a) If the patient is covered by a health benefit plan issued by the carrier and payment of the premium for the health benefit plan has been received by the carrier, notify the provider of health care that the patient is covered by a health benefit plan issued by the carrier;***

***(b) If the patient is not covered by a health benefit plan issued by the carrier, notify the provider of health care that the patient is not covered by a health benefit plan issued by the carrier; or***

***(c) If the patient is covered by a health benefit plan issued by the carrier, the payment of the premium for the health benefit plan has not been received by the carrier and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a health benefit plan issued by the carrier;***

***(2) The premium on that health benefit plan has not been received by the carrier; and***

***(3) If the carrier does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the health benefit plan for any claim made during the grace period.***

***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 7.** Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from a society pursuant to paragraph (c) of subsection 5 of NRS 695A.095:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the society a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the society for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the society, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 8.** NRS 695A.095 is hereby amended to read as follows:

695A.095 1. A society shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the society to its insureds.

2. A society shall not contract with a provider of health care to provide health care to an insured unless the society uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a society and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the society upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a society contracts with a provider of health care to provide health care to an insured, the society shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

5. ***If a provider of health care requests that a society verify whether a patient of the provider of health care is covered by a benefit contract, the society shall:***

***(a) If the patient is covered by a benefit contract issued by the society and payment of the premium for the benefit contract has***

***been received by the society, notify the provider of health care that the patient is covered by a benefit contract issued by the society;***

***(b) If the patient is not covered by a benefit contract issued by the society, notify the provider of health care that the patient is not covered by a benefit contract issued by the society; or***

***(c) If the patient is covered by a benefit contract issued by the society, the payment of the premium for the benefit contract has not been received by the society and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a benefit contract issued by the society;***

***(2) The premium on that benefit contract has not been received by the society; and***

***(3) If the society does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the benefit contract for any claim made during the grace period.***

6. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 9.** Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from a corporation pursuant to paragraph (c) of subsection 5 of NRS 695B.035:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the corporation a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the corporation for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the corporation, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 10.** NRS 695B.035 is hereby amended to read as follows:

695B.035 1. A corporation subject to the provisions of this chapter shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the corporation to its insureds.

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the corporation uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a corporation specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the corporation upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a corporation specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the corporation shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

5. ***If a provider of health care requests that a corporation specified in subsection 1 verify whether a patient of the provider of health care is covered by a contract, the corporation shall:***

***(a) If the patient is covered by a contract issued by the corporation and payment of the premium for the contract has been received by the corporation, notify the provider of health care that the patient is covered by a contract issued by the corporation;***

***(b) If the patient is not covered by a contract issued by the corporation, notify the provider of health care that the patient is not covered by a contract issued by the corporation; or***

***(c) If the patient is covered by a contract issued by the corporation, the payment of the premium for the contract has not been received by the corporation and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a contract issued by the corporation;***

***(2) The premium on that contract has not been received by the corporation; and***

***(3) If the corporation does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the contract for any claim made during the grace period.***

***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 11.** Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from a health maintenance organization pursuant to paragraph (c) of subsection 4 of NRS 695C.125:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the health maintenance organization a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the health maintenance organization for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the health maintenance organization, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 12.** NRS 695C.125 is hereby amended to read as follows:

695C.125 1. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless the health maintenance organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a health maintenance organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the health maintenance organization upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a health maintenance organization contracts with a provider of health care to provide health care to an enrollee, the health maintenance organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

4. ***If a provider of health care requests that a health maintenance organization verify whether a patient of the provider of health care is covered by a health care plan, the health maintenance organization shall:***

***(a) If the patient is covered by a health care plan issued by the health maintenance organization and payment of the premium for the health care plan has been received by the health maintenance organization, notify the provider of health care that the patient is covered by a health care plan issued by the health maintenance organization;***

***(b) If the patient is not covered by a health care plan issued by the health maintenance organization, notify the provider of health care that the patient is not covered by a health care plan issued by the health maintenance organization; or***

***(c) If the patient is covered by a health care plan issued by the health maintenance organization, the payment of the premium for the health care plan has not been received by the health***

***maintenance organization and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a health care plan issued by the health maintenance organization;***

***(2) The premium on that health care plan has not been received by the health maintenance organization; and***

***(3) If the health maintenance organization does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the health care plan for any claim made during the grace period.***

***5.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

**Sec. 13.** Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:

***If a provider of dental care receives notification from an organization for dental care pursuant to paragraph (c) of subsection 3 of NRS 695D.215:***

***1. The provider of dental care shall inform the patient who is the subject of the notification:***

***(a) That the provider of dental care has received such notification; and***

***(b) That the provider of dental care:***

***(1) May charge the patient for the dental care services provided to the patient;***

***(2) Will submit to the organization for dental care a claim for payment of the dental care services provided to the patient; and***

***(3) Will comply with the provisions of subsection 2.***

***2. The provider of dental care shall, if it charges the patient who is the subject of the notification for the dental care services provided to the patient and subsequently receives payment from the organization for dental care for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the organization for dental care, less any applicable copayments, deductibles or coinsurance amounts.***

**Sec. 14.** NRS 695D.215 is hereby amended to read as follows:

695D.215 1. Except as otherwise provided in subsection 2, an organization for dental care shall approve or deny a claim relating to a plan for dental care within 30 days after the organization for dental care receives the claim. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the organization for dental care shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The

interest must be calculated from the date the payment is due until the claim is paid.

2. If the organization for dental care requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The organization for dental care shall notify the provider of dental care of the reason for the delay in approving or denying the claim. The organization for dental care shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the organization for dental care shall pay interest on the claim in the manner prescribed in subsection 1.

***3. If a provider of dental care requests that an organization for dental care verify whether a patient of the provider of dental care is covered by a plan for dental care, the organization for dental care shall:***

***(a) If the patient is covered by a plan for dental care issued by the organization for dental care and payment of the premium for the plan for dental care has not been received by the organization for dental care, notify the provider of dental care that the patient is covered by a plan for dental care issued by the organization for dental care;***

***(b) If the patient is not covered by a plan for dental care issued by the organization for dental care, notify the provider of dental care that the patient is not covered by a plan for dental care issued by the organization for dental care; or***

***(c) If the patient is covered by a plan for dental care issued by the organization for dental care, the payment of the premium for the plan for dental care has not been received by the organization for dental care and the grace period for the payment of the premium has not expired, notify the provider of dental care that:***

***(1) The patient is covered by a plan for dental care issued by the organization for dental care;***

***(2) The premium on that plan for dental care has not been received by the organization for dental care; and***

***(3) If the organization for dental care does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the plan for dental care for any claim made during the grace period.***

**Sec. 15.** Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

***1. If a provider of health care receives notification from a managed care organization pursuant to paragraph (c) of subsection 4 of NRS 695G.430:***

***(a) The provider of health care shall inform the patient who is the subject of the notification:***

***(1) That the provider of health care has received such notification; and***

***(2) That the provider of health care:***

***(I) May charge the patient for the health care services provided to the patient;***

***(II) Will submit to the managed care organization a claim for payment of the health care services provided to the patient; and***

***(III) Will comply with the provisions of paragraph (b).***

***(b) The provider of health care shall, if it charges the patient who is the subject of the notification for the health care services provided to the patient and subsequently receives payment from the managed care organization for all or part of those services, reimburse the patient to the extent that the amount paid by the patient is covered by the managed care organization, less any applicable copayments, deductibles or coinsurance amounts.***

***2. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.***

**Sec. 16.** NRS 695G.430 is hereby amended to read as follows:

695G.430 1. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless the managed care organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a managed care organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the managed care organization upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a managed care organization contracts with a provider of health care to provide health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS, the managed care organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

4. ***If a provider of health care requests that a managed care organization verify whether a patient of the provider of health care is covered by a health care plan, the managed care organization shall:***

***(a) If the patient is covered by a health care plan issued by the managed care organization and payment of the premium for the health care plan has been received by the managed care organization, notify the provider of health care that the patient is covered by a health care plan issued by the managed care organization;***

***(b) If the patient is not covered by a health care plan issued by the managed care organization, notify the provider of health care that the patient is not covered by a health care plan issued by the managed care organization; or***

***(c) If the patient is covered by a health care plan issued by the managed care organization, the payment of the premium for the health care plan has not been received by the managed care organization and the grace period for the payment of the premium has not expired, notify the provider of health care that:***

***(1) The patient is covered by a health care plan issued by the managed care organization;***

***(2) The premium on that health care plan has not been received by the managed care organization; and***

***(3) If the managed care organization does not receive payment of the premium before the expiration date of the grace period, the patient will not be covered by the health care plan for any claim made during the grace period.***

***5.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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