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Call Center: 800.547.2927
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NevadaHealthLink.com

Letter of Explanation

If you have received a notice from the Nevada Health Link requesting that you submit documents to confirm a life event, you will need to email or mail documents to Nevada Health Link. If you cannot provide the requested documents, you may submit this "letter of explanation."

To complete this form, save this file to your computer, fill out the section that's related to your life event, and email this form to: customerserviceNVHL@exchange.nv.gov. If you need more space, you may include an additional document or sheet.

Disclaimer: The information requested below is to provide Nevada Health Link justification as to why you cannot submit the generally requested documents pertaining to your reported change. The information provided on this form will not be used to alter information within your application. You must report life event (e.g., loss of coverage, move, marriage, denial of Medicaid or CHIP during open enrollment, adoption, foster care placement, court order or gain of tax dependent) changes through your application.

Your Name: _____

Your Application ID: _____

Loss of Coverage/Prior Coverage (Must have been Minimum Essential Coverage)

What kind of coverage did you/do you have?
When did you/will you lose coverage?
Why are you losing your coverage?

Why can't you submit the requested documents?

Move

Check this box if you had health coverage at least one day during the 60 days before your move.

Check this box if you moved from a foreign country or U.S. territory.

When Did you Move?

What's your old (physical) address?

What's your new (physical) address?

What is your mailing address?

Why can't you submit the requested documents?

Marriage

Check this box if you or your spouse had health coverage at least one day during the 60 days before getting married.

When did the marriage take place?

Who was married?

Are there additional details we should know about the marriage?

Why can't you submit the requested documents?

Denial of Medicaid or CHIP Coverage (only applicable if you applied during an enrollment period and were denied after the enrollment period)

Date of Medicaid/CHIP Application

Date of Medicaid/CHIP Denial

Who was denied coverage through Medicaid or CHIP? List names of everyone denied, please.

Why can't you submit the requested documents?

Adoption, Foster Care Placement, Court Order or Gain of Tax Dependent

Date of Event:

Who was adopted, placed in foster care, or became a dependent through a court order or by IRS standards? List names of everyone on your application who this applies to.

Is there any other information you'd like to include about the adoption, foster care placement, court order, or tax dependent?

Why can't you submit the requested documents?

Income Verification/Loss of Income* (*Income verification may be applicable for any enrollment. If you are enrolling through a "Loss of Income" SEP, you will also need to provide evidence of prior coverage)

What is your income?

When did your income change (*if applicable)?

What was your income prior to change (*if applicable)?

Why did your income change (* if applicable)?

Why can't you submit the requested documents?

Additional Information: