



**ILLINOIS NONPARTICIPATING FACILITY-BASED PHYSICIANS
AND PROVIDERS / INSURER OR HEALTH PLAN**

Demand for Arbitration Pursuant to Illinois Insurance Code, Section 356z.3a

To: Name of Respondent:		
Address:		
City:	State:	Zip Code:
Phone No.:	Fax No.:	
Email Address:		
Name of Representative (if known):		
Representative's Address:		
City:	State:	Zip Code:
Phone No.:	Fax No.:	
Email Address:		
The Nature of the Dispute:		
Dollar Amount of Claim: \$		
Other Relief Sought: Attorneys Fees Interest Arbitration Costs		
Amount enclosed: \$ in accordance with the Standard Fee Schedule.		
Type of Business:		
Claimant: Respondent:		
You are hereby notified that a copy of this Demand is being filed with the American Arbitration Association with a request that it commence administration of the arbitration. The AAA will provide you notice of your opportunity to file an answering statement.		
Signature (may be signed by a representative):	Title:	Date:
Name of Claimant:		
Address (to Be Used in Connection with This Case):		
City:	State:	Zip Code:
Phone No.:	Fax No.:	
Email Address:		



Name of Representative:		
Name of Firm (if Applicable):		
Representative's Address:		
City:	State:	Zip Code:
Phone No.:	Fax No.:	
Email Address:		
To begin proceedings, please send a copy of this Demand, along with the filing fee as provided for in the Rules to: American Arbitration Association, Case Filing Services, 1101 Laurel Oak Road, Suite 100, Voorhees, NJ 08043. Send the original Demand to the Respondent. Also send a copy of this Demand to the Illinois Department of Insurance at doi.arbitrationrequest@illinois.gov . Please visit our website www.adr.org if you would like to file a case online. AAA Case Filing Services can be reached at 1-877-495-4185.		