



AMERICAN ARBITRATION ASSOCIATION®

**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 Cost		
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:		

**Please visit our website at www.adr.org/support to file this case online.
AAA Customer Service can be reached at 800-778-7879.**



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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 file online at www.adr.org/fileonline . You will need to upload a copy of this Demand and pay the appropriate fee. 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 .		

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