# State of Connecticut
## Emergency Room Copayment Waiver Request
CO-1315 REV 10/2017

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

**This form must be completed by an employee seeking a waiver of an Emergency Room Copayment of $250. Submit this form to your Carrier. You must provide all requested information. Incomplete forms will be returned. Your waiver request will be processed within 60 days. (Note: If you have already paid your co-pay, you will need to seek reimbursement from the hospital if the waiver request is granted.)**

| **Employee Name (Last Name, First Name, MI)** | **Employee No.** | **Employee Medical ID #** |
|---|---|---|
| **Street Address** | **Personal Email Address** (Do not use your work email address) | **Home/Cell Phone No.** (For privacy reasons do not provide your work phone number) ( ) - |
| **City, State, Zip Code** | | **Patient's Medical ID #** |
| **Patient Name** | **Relationship to Subscriber** | **Date of Birth** |
| **Place of Treatment** | **Date of Treatment** | **Time of Treatment (Must be provided)** ☐ **a.m.** ☐ **p.m.** |
| **Condition for which Emergency treatment was sought:** | | |

The $250 copayment for usage of an emergency room may be waived when the subscriber had no reasonable medical alternative. The absence of a reasonable medical alternative is determined by reference to the following circumstances. Check all boxes that apply to the Emergency Room visit that you are seeking reimbursement for. **Failure to specify time of day or to fill in information will delay processing and may result in the denial of your request. Attach a copy of your ER discharge summary with this form.**

**REQUIRED (check all appropriate boxes):**

☐ **The patient identified above had a Medical Emergency that placed his or her health in serious jeopardy or at risk of impairment to any bodily organ or at risk of serious disfigurement.**

☐ I called my Carrier's 24-hour nurse line at the number listed on my medical ID card and was advised to go to the Emergency Room.

☐ I called my primary care doctor, _____, and was advised to go to the Emergency Room based on the severity of my condition.

☐ The office of my primary care doctor, _____, was closed and I was experiencing a medical emergency.

☐ The nearest walk-in clinic or Urgent Care center was closed and I was experiencing a medical emergency.

☐ My child's school, _____, sent him/her to the Emergency Room per established policy
(Print Name of School)

By signing this form, I hereby certify that the information provided is true and complete to the best of my knowledge. I understand that if I have knowingly given incorrect information, I may be subject to penalties for false statement. I authorize the Office of the State Comptroller to verify any information given on this form.

| **EMPLOYEE SIGNATURE** | **DATE** |
|---|---|
| | |

**Anthem Subscribers**: Return form to Anthem/State of CT, PO Box 554, North Haven, CT 06473 or fax to 855-394-3747

**Oxford Subscribers:** Return form to Oxford HealthCare, PO Box 29130, Hot Springs, AR 71903 or fax to 888-454-0386