

State of Connecticut Emergency Room Copayment Waiver Request

CO-1315 REV 2/2017



This form must be completed by an employee seeking a waiver of an Emergency Room Copayment of \$35. Submit this form to your Carrier. Your waiver request will be processed within 60 days. You must provide all requested information. Incomplete forms will be returned. (Note: If you have already paid your co-pay, you will need to seek reimbursement from the hospital after the waiver request is processed.)

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) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Condition for which Emergency treatment was sought:		

The \$35 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 that apply to the Emergency Room visit for which reimbursement is sought: **Failure to specify time of day or to fill in information where requested will delay processing of your request.**

<input type="checkbox"/> 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.
<input type="checkbox"/> I called my primary care doctor, _____, and was advised to go to the Emergency Room. <small>(Print Name of Primary Care Physician)</small>
<input type="checkbox"/> The office of my primary care doctor, _____, was closed. <small>(Print Name of Primary Care Physician)</small>
<input type="checkbox"/> The nearest walk-in clinic or Urgent Care center was closed.
<input type="checkbox"/> My child's school, _____, sent him/her to the Emergency Room per established policy <small>(Print Name of School)</small>
<input type="checkbox"/> 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.

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
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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