

# State of Connecticut Emergency Room Copayment Waiver Request

CO-1315 REV 3/2012



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.)

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

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.**

- 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.

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- I called my primary care doctor, \_\_\_\_\_, or urgent care center, \_\_\_\_\_ and was advised to go to the Emergency Room.  
(Print Name of Primary Care Physician) (Print Name of Urgent Care Center)

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- The office of my primary care doctor, \_\_\_\_\_, was closed and the nearest walk-in clinic or urgent care center was closed.  
(Print Name of Primary Care Physician)

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- My child's school, \_\_\_\_\_, sent him/her to the Emergency Room per established policy.  
(Print Name of School)

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- 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.

<b>EMPLOYEE SIGNATURE</b>	<b>DATE</b>
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**Anthem Subscribers:** Return form to Anthem/State of CT, PO Box 554, North Haven, CT 06473 or fax to 203-985-6358

**Oxford Subscribers:** Return form to Oxford HealthCare, PO Box 7081, Bridgeport, CT 06610 or fax to 888-454-0386