State of Connecticut
Emergency Room Copayment Waiver Request

CO-1315 REV 3/2012

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 $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 Name**	**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 $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.

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

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

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

☐ 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**

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