State of Connecticut
Emergency Room Copayment Waiver Request

CO-1315 REV 5/2019

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services
Division
165 Capital Avenue
Hartford, CT 06106-1775

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: Please do not submit this form until you have received an Explanation of Benefits from your insurance company. 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. All forms must be submitted within 180 days of the ER service. 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. (Print Name of Primary Care Physician and telephone number)

☐ The office of my primary care doctor, _____, (Print Name of Primary Care Physician and telephone number) was closed and other alternative options like walk-in clinics and urgent care centers either are not available in my area or were also closed and I was experiencing a medical emergency.

☐ My child's school, _____, sent him/her to the Emergency Room per established policy.

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

* $35 copay for Pre-October 2, 2017 non-Medicare retirees.