# State of Connecticut
## Lab and Radiology Coinsurance Waiver Request

CO-1331 (04/2021)

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

**This form must be completed by an employee seeking a waiver of coinsurance charged in connection with lab or radiology services at a non-preferred site of service provider. 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 coinsurance, you will need to seek reimbursement from the provider if the waiver request is granted.)**

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|---|---|---|
| **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 service was sought:** | | |

The coinsurance for usage of lab or radiology services may be waived when use of a non-preferred site of service provider was medically necessary. Medical necessity is determined by reference to the circumstances below. Check all boxes below that apply to the lab or radiology services for which you are seeking a waiver of coinsurance. **Failure to fill in all applicable information will delay processing and may result in the denial of your request. All forms must be submitted within 180 days of the service. Attach a copy of your provider bill with this form.**

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

☐ **The lab or radiology service is associated with an ongoing cancer treatment.**

☐ **The lab or radiology service is associated a transplant.**

☐ **The radiology service is associated with a pregnancy.** (Please note the automatic waiver for services associated with a pregnancy only applies to radiology. Coinsurance for lab services associated with a pregnancy at a non-preferred site of service provider will not be automatically waived, but can be reviewed for medical necessity)

☐ **The radiology service was for a patient under 10 years old.**

☐ The lab or radiology provider I used was listed as a preferred site of service provider on the list available on the carrier's custom website for State of Connecticut Partnership Plan members. (Appropriate documentation must be submitted, i.e. screen shot, printed list)

The service required is not available at a preferred site of service provider in my area (radius of 20 miles).

☐ Please list service or services required:

Patient address:

☐ My physician requires, for reasons of medical necessity, that the service be provided by a specific non-preferred site of service provider. **(Please have your physician complete information on the next page if this box is checked)**

| Provider Name/Name of Clinic | Provider ID # (if applicable) | Phone<br>(  )  - | Fax<br>(  )  - |
|---|---|---|---|
| Office Address – Number and Street Name | City | State | Zip |
| Provider Signature | | Tax ID # | Date |

| Physician/Providers – Please provide a brief explanation of medical necessity for utilizing specific lab or radiology provider: |
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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 |
|---|---|
| | |

***Approval of any exception is no guarantee that future exceptions will be granted. Return form to Anthem by mail, fax or email:**

**Mail to Anthem/State of CT, PO Box 554, North Haven, CT 06473**

**Fax to 855-394-3748**

**Email to NECorrespondence@anthem.com**