State of Connecticut
Lab Coinsurance Waiver Request
CO-1331 REV 6/2023

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
CareCompass.CT.gov

Submit this form to Quantum Health using the address below. This form must be completed by a plan member seeking a waiver of coinsurance charged in connection with lab services at a non-preferred site of service provider. 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.)

Employee Name (Last Name, First Name, MI)	**Employee #/ Partnership Group.**	**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**
Name of Lab	**Date of Service**	

The coinsurance for usage of lab 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 service is associated with an ongoing cancer treatment.**
- ☐ **The lab service is associated with a transplant.**
- ☐ The lab provider I used was listed as a preferred site of service provider on the list available on the Care Compass **w**ebsite for State of Connecticut 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	Fax
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 provider:

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 Quantum Health via mail or fax.

Mail: Quantum Health, 5240 Blazer Parkway, Dublin,OH 43 017 | Fax: 855-475-5963 | Email: SOCWaiverRequests@quantum-health.com