

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 website 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)**

