

**State of Connecticut  
Health Enhancement Program**

CO-1317 REV 01/2016



**PHYSICIAN NOTIFICATION FORM**

**Important Information**

This form should be used if your provider does not feel it is clinically appropriate for you to have a screening required by HEP, or if you have completed a requirement that is not available in existing claim data. You must have your provider complete and sign this form. It will be your responsibility to submit this form to the Health Enhancement Program as shown below.

**INSTRUCTIONS FOR PHYSICIANS/PROVIDERS:** Please use this form to report a member's exemption from or completion of specific examinations or health screenings. To do so, check the appropriate screening/service and be sure to initial next to the corresponding item. If applicable, please briefly describe the reasons for any exemptions, and sign the bottom.

**Submit Completed Physician Notification Forms To:**

State of Connecticut Health Enhancement Program  
PO Box 4050  
175 Scott Swamp Road  
Farmington, CT 06034-4050  
ATTN: Health Navigation Specialists  
Fax Number – 855-207-1640

<b>Member Information</b> (Required and must match exactly to what is listed on your Medical/Dental Plan ID card.)			
<b>Member Identification Number</b>	<b>Group Number</b>	<b>Employee ID</b>	<b>Dept ID</b>
<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Date of Birth (MM/DD/YY)</b>
			/ /
<b>Home Address – Number and Street Name</b>		<b>City</b>	<b>State</b> <b>Zip Code</b>
<b>Telephone</b>		<b>Email Address</b>	
(   ) -			
<b>Member or Parent/Guardian Signature</b>			<b>Date</b>
X			/ /
<b>Provider Information</b> (Required)			
<b>Provider Name / Name of Clinic</b>	<b>Provider ID # (If Applicable)</b>	<b>Telephone</b>	<b>Fax</b>
		(   ) -	(   ) -
<b>Office Address – Number and Street Name</b>		<b>City</b>	<b>State</b> <b>Zip Code</b>
<b>Provider Signature</b>		<b>Tax ID #</b>	<b>Date</b>
X			/ /

Member Identification Number		Group Number	Employee ID	Dept ID
Last Name		First Name	Middle Initial	Date of Birth (MM/DD/YY)
				/ /

**(Provider Use Only)**

Check Applicable Box on Left for Each Item Being Reported		Completed (MM/DD/YY)	Exempt	Provider Initials
<input type="checkbox"/>	<b>Preventive Visit</b>	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Vision Exam</b>	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Cholesterol Screening</b> Once every 5 years ages 20 - 49, and every 2 years ages 50+	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Mammography</b> One screening between the age of 35 and 39; otherwise as recommended by Physician	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Colorectal Cancer Screening</b> Fecal Occult or FIT annually or Colonoscopy every 10 years beginning at age 50 to age 75	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Cervical Cancer Screening</b> (ages 21+) One screening required every 3 years to age 65	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
<input type="checkbox"/>	<b>Dental Cleaning(s)</b> (At least one per year)	/ /	<input type="checkbox"/> Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	

Physicians/Providers – Please provide a brief explanation for any items exempted above:

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Provider Signature	Date
X	/ /