# State of Connecticut
## Health Enhancement Program
CO-1317 REV 5/2013

# 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 – 877-687-1449

**Member Information** (Required and must match exactly to what is listed on your Medical/Dental Plan ID card.)

| Member Identification Number | Group Number | Employee ID | Dept ID |
|---|---|---|---|
| | | | |

| Last Name | First Name | Middle Initial | Date of Birth (MM/DD/YY) |
|---|---|---|---|
| | | | / / |

| Home Address – Number and Street Name | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Telephone | Email Address |
|---|---|
| ( ) - | |

| Member or Parent/Guardian Signature | Date |
|---|---|
| X | / / |

**Provider Information** (Required)

| Provider Name / Name of Clinic | Provider ID # (If Applicable) | Telephone | Fax |
|---|---|---|---|
| | | ( ) - | ( ) - |

| Office Address – Number and Street Name | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Provider Signature | Tax ID # | Date |
|---|---|---|
| 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 |
|---|---|---|---|---|---|
| ☐ | **Preventive Visit** | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Vision Exam** | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Cholesterol Screening**<br>Once every: 5 years (ages 20-29), 3 years (ages 30-39), 2 years (ages 40-49) and every year (ages 50+) | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Breast Exam** (Females Only)<br>One Clinical Breast Exam required every 3 years | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Mammography**<br>One screening between the age of 35 and 39; otherwise as recommended by Physician | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Colorectal Cancer Screening**<br>Fecal Occult or FIT annually or Colonoscopy every 10 years beginning at age 50 | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Cervical Cancer Screening**<br>(ages 21+)<br>One screening required every 3 years | / / | ☐ | Member is exempt from completion due to a medical condition or other health factors; also see brief detail below. | |
| ☐ | **Dental Cleaning(s)**<br>Two per year (only one will be required for 2013) | / / | ☐ | 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:

| Provider Signature | Date |
|---|---|
| X | / / |