State of Connecticut
Health Enhancement Program
CO-1320 REV 01/2016

APPLICATION FOR REINSTATEMENT OF FINANCIAL INCENTIVES
HEP ACTIVE STATUS
Important Information

This form must be used by employees who are ineligible for financial incentives under the Health Enhancement Program (HEP) because they or an enrolled dependent failed to complete one or more HEP requirements. Use this form to document fulfillment of outstanding requirements and seek reinstatement to HEP active status.

Your provider must complete page 2 of this form to record completion of a preventive requirement or to provide an explanation of why it is clinically inadvisable for an individual to complete a HEP-required screening.

If you failed to complete the chronic disease education and counseling, you must do so in order to be reinstated. Once you have completed the requirement, check the box at the bottom of this page, fill in the date you did so, and sign the application for reinstatement. **Note: Your physician does not need sign off on your completion of the chronic education and counseling requirement.**

It is the employee's responsibility to submit this form to the state's HEP administrator, Care Management Solutions, after you and all enrolled dependents have fulfilled all outstanding HEP requirements. A separate form must be submitted for each non-compliant member.

Submit Completed Applications To:

State of Connecticut Health Enhancement Program
PO Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050
ATTN: Health Navigation Specialists
Fax Number – 855-207-1241

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

Member Health Plan Identification Number	Group Number	State Employee ID

Employee/Retiree: Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /

Non-Compliant Person: 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 Signature	Date
X	/ /

		Completed (MM/DD/YY)
☐	Chronic Disease Education and Counseling	/ /

INSTRUCTIONS FOR PHYSICIANS/PROVIDERS: Please use this form to report this member's completion of a required health screening/service. To do so, check the appropriate screening/service, complete the date of service, place your initials next to the corresponding item, and sign the bottom.

If it is determined that a required screening is not medically advisable for the member noted below, you must also provide additional details in the space provided below.

Non Compliant Person: Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /

(Provider Use Only)					
Please only check the items that need to be completed for compliance.		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.	
☐	**Cholesterol Screenings** Once every 5 years ages 20 – 49, and every 2 years age 50+	/ /	☐	Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
☐	**Mammography** Required for every female between the ages of 35 and 39 or as recommended by Physician	/ /	☐	Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
☐	**Cervical Cancer Screening** (ages 21+) One screening required every 3 years to age 65	/ /	☐	Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
☐	**Dental Cleaning**	/ /	☐	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.	
☐	**Colorectal Cancer Screening** Fecal Occult or FIT annually or Colonoscopy every 10 years beginning at age 50 to age 75	/ /	☐	Member is exempt from completion due to a medical condition or other health factors; also see brief detail below.	
Providers – Please provide a brief explanation for any items exempted above:					

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
		/ /

Submit Completed Applications To: State of Connecticut Health Enhancement Program
PO Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050
ATTN: Health Navigation Specialists
Fax Number – 855-207-1241