HEALTH ENHANCEMENT PROGRAM (HEP)
BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

Health Enhancement Program (HEP) Medical Exemption Form

If you are unable to participate in your State of Connecticut's Health Enhancement Program — or if it is medically inadvisable for you to complete any of the required activities — you may be eligible to have your participation waived and still receive the credit toward your compliance. To be eligible to receive credit for these activities, complete all the applicable fields. Please note that for medical exemptions, you must have your physician sign and submit this form to Quantum Health by the program's deadline. **ALL APPLICABLE FIELDS MUST BE FILLED OUT FOR THE FORM TO BE PROCESSED!**

- **If you are requesting a medical exemption, this form must be completed by both you and your physician**
- **Submit via email at HEPforms@quantum-health.com or fax to (855) 475-5963 by the deadline**
- **If you have any questions, please call your Quantum Health Care Coordinators at (833) 740-3258**

PART I — TO BE COMPLETED BY EMPLOYEE/RETIREE

Please **print** legibly. Incomplete or illegible forms will not be processed. Write your first and last name exactly the way they appear on your payroll stub and/or your medical ID card.

Member ID Number:		**Group Number:**
Employee/Retiree First name:		**Employee/Retiree Last name:**
Date of birth (MM/DD/YY):	**Gender:**	**Last 4 digits of SSN:**
Phone #:		**Email:**
Home Address:		**City:**
State:		**Zip Code:**

Name of Member Requesting Exemption:
Member ID:
Date of Birth (MM/DD/YY):

MEDICAL EXEMPTION – COMPLETE ALL FIELDS

MEMBER AUTHORIZATION: By completing this form, I am authorizing my physician to report the medical reasons that support the need to waive the Health Enhancement Program activities established by my employer/former employer. I have provided this form to my physician and authorize him or her to send the requested information to Quantum Health.

Member signature:	**Date:**

CARE COMPASS | Quantum HEALTH

PART II — TO BE COMPLETED BY PHYSICIAN

If there is a medical reason why the above patient should not or cannot complete any of the following requirements, please complete and sign this form in the space provided below. Please print legibly and complete all fields.

Check the applicable box for each item being reported. If a member should be exempt from completion due to a medical condition or other health factors, please provide a brief description in the *Explanation* field below.

☐	**Preventive Visit**	**Provider Initials:**
☐	**Vision Exam**	**Provider Initials:**
☐	**Cholesterol Screening** (Every 5 years for ages 20+)	**Provider Initials:**
☐	**Mammography** One screening between the age of 45-49 Every year for ages 50+	**Provider Initials:**
☐	**Colorectal Cancer Screening** 45+ every 10 years, annual FIT/FOBT to age 75, or Cologuard screening every 3 years	**Provider Initials:**
☐	**Cervical Cancer Screening** (Ages 21+) One screening required every 3 years to age 65	**Provider Initials:**
☐	**Dental Cleaning(s)** (At least one per year)	**Provider Initials:**

PHYSICIAN ATTESTATION: I am knowledgeable about this patient's medical history and current health status. I recommend that the member's participation be waived from the required activities and have provided an explanation for the requested waiver below.		
Explanation — Reason why patient cannot complete the Health Enhancement Program:		
Physician name:		**Physician Signature:**
Date:	**UPIN/NPI:**	**Physician Phone #:**