Postpartum Care Notification Form

To qualify for the incentive:

- Complete this form and **fax to California Health & Wellness** within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, certified nurse midwife, or licensed midwife.
- The postpartum visit must be between three and eight weeks (21 to 56 days) after delivery.
- This form must be kept in the patient's medical record.

Fax to: 1-877-783-0287

Date of postpartum visit: _____

Member Information

First name:	**Last name:**
Medi-Cal ID # (CIN #):	**Date of birth:**
9	**Telephone number:**
Address:	**City:** / **ZIP code:**

Primary Language

☐ **English** ☐ **Spanish** ☐ **Vietnamese** ☐ **Mandarin** ☐ **Farsi** ☐ **Korean** ☐ **Arabic** ☐ **Other:**_____

Postpartum Assessment

Date of delivery: _____ **Hospital:** _____

☐ **Confirmation of live birth** **BP:** _____ **Weight:** _____

Abdomen	☐ **Normal** ☐ **Abnormal**	**Comments:**
Breasts	☐ **Normal** ☐ **Abnormal** ☐ **Breastfeeding**	**Comments:**

OR

Pelvic	**Uterus:**_____ **Cervix:** _____ **Other comments:**	**Pap test: (optional)** ☐ **Normal** ☐ **Abnormal**

Additional comments/visit notes:

Provider Information

Practitioner name:		**Clinic name:**	
Practitioner NPI:	**Specialty (OB/GYN, PCP, NP, or CNM):**	**Clinic address:**	
Office contact name:		**City:**	**County:**
Office telephone number:		**ZIP code:**	

☐ **I confirm that this document is filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**