CONFIRMATION OF PREGNANCY FORM

To qualify for the incentive:

- Complete this form for California Health & Wellness Plan (CHWP) members only and fax to CHWP within seven days of the visit.
- This form must be signed by a primary care physician (PCP), nurse practitioner (NP), or physician's assistant (PA).
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into CHWP.

Fax to CHWP at 877-783-0287

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Phone number:**	
Address:	**City:**	**ZIP code:**
Medical group name (also known as IPA):		

Member Primary Spoken Language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin ☐ Farsi ☐ Korean ☐Arabic ☐ Other_____

Pregnancy Information - Required

Date of visit with provider: _____

Pregnancy diagnosis confirmed: ☐ **Yes** **LMP:**_____ **or EDD:**_____	**Is this a high-risk pregnancy?** ☐ **Yes** ☐ **No**

Rendering Practitioner Information

Practitioner name:		**Clinic name:**
Practitioner NPI:	☐ **PCP** ☐ **NP** ☐ **PA**	**Clinic address:**
Office contact name:		**City:** / **County:**
Office phone number:		**ZIP code:**

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

Practitioner signature:	**Date signed:**