

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 # (C	IN #):					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:	LMP: or EDD:						Is this a high-risk pregnancy? Yes No			
Rendering Practitioner Information										
Practitioner name:						Clinic name:				
Practitioner NPI: 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:				

CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments. If you no longer wish to receive fax notices from Provider Communications, please email us at provider.communications@healthnet.com indicating the fax number(s) covered by your request. We will comply with your request within 30 days or less.