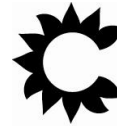




Children First™ Prenatal Program Form



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Congratulations on your pregnancy! Community Health Plan of Washington members are eligible to receive a certificate for a *FREE convertible car seat*. To be eligible, the member must currently be pregnant AND:

- See her provider within the first trimester; OR
- If new to Community Health Plan, see her provider within 42 days of joining.

THIS FORM MAY BE REDEEMED FOR A CAR SEAT CERTIFICATE ONLY AFTER COMPLETING THE 1st PRENATAL VISIT IN 3rd TRIMESTER.

Please complete the following. Your provider's office will fax this form to Community Health Plan. **If you are eligible you will receive a certificate in the mail within 3 weeks to redeem your reward. If you do not receive your gift after 3 weeks or if you have a question, please contact Customer Service, 1-800-440-1561.**

I request and authorize the disclosure of pregnancy-related protected health information to be released to Community Health Plan to confirm eligibility to receive a car seat as part of the prenatal program:

Member name: _____

Mailing address _____

City/State/Zip _____ Current phone number: _____

Community Health Plan member number: _____ Member's date of birth: ____/____/____

Date of 1st doctor visit in 3rd trimester: ____/____/____ Today's date ____/____/____

New Community Health Plan member (within last 2 months)? Yes No

HIPAA Disclaimer: This request and authorization to disclose applies to the following and is valid six (6) months after the appointment date or at the end of current pregnancy. To revoke authorization at any time, call Customer Service at 1-800-440-1561.

Member's Signature _____ Date ____/____/____

To be completed by clinic staff:

Provider's name: _____
(print)

Clinic staff signature: _____

Expected delivery date: ____/____/____ Date of 1st prenatal visit: ____/____/____

Expecting multiple births (twins, etc)? Yes No **If yes, please specify:** _____

For tracking and verification, please include your T.I.N (tax ID number) in the box to the right.

Please fax the completed form to:
Community Health Plan of Washington
ATTN: Children First Program
Fax: (206) 652-7071
OR email: childrenfirst@chpw.org