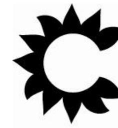
Children First™ Well Child / Immunization Program Form



COMMUNITY HEALTH PLAN of Washington

Committed to your health.

Children who are Community Health Plan of Washington members are eligible to receive a reward for getting care. To be eligible the member must:

- **See his/her provider for the scheduled well child exam; AND**
- **Be current on all scheduled immunizations; AND**
- **Be a Community Health Plan member on the appointment date and when the provider submits the form.**

Please check one (1) of the following rewards for the eligible member's well-child appointment (reward must link with the appropriate appointment):

Infancy (newborn – 9 months): *certificate for free:*	**Early Childhood (12 months – 4 years):** *certificate for free:*
☐ *Welcome Baby Kit* ☐ *Cupboard Locks* ☐ *Thermometer* ☐ *Diapers* ☐ *Car Seat (limit one)*	☐ *Children's Books* ☐ *Diapers* ☐ *Thermometer* ☐ *Bike Helmet* ☐ *Cupboard Locks* ☐ *Dental Care Pack*
Middle Childhood (5 to 10 years): *certificate for free:*	**Adolescent (11 to 13 years):** *certificate for free:*
☐ *Bike Helmet* ☐ *Booster Seat* ☐ *School Supplies* ☐ *Clothes* ☐ *Backpack* ☐ *Dental Care Pack*	☐ *Backpack* ☐ *Clothes* ☐ *Bike Helmet* ☐ *Dental Care Pack* ☐ *School Supplies*

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 certificate after 3 weeks or if you have a question, please contact Community Health Plan Customer Service, 1-800-440-1561.**

I request and authorize the disclosure of protected health information **for the child member**, including protected health information about the HPV vaccine, to be released to Community Health Plan for the purpose of confirming eligibility to receive an incentive as part of the Children First Well Child program:

Name of child: ____

Mailing address ____

City/State/Zip ______________________________ Current phone number: ______________

Child's Community Health Plan member number: ________________ Child's date of birth: ___/___/___

Parent/Guardian date of birth: ___/___/____ Appointment date: ____/____/____ Today's date ____/____/____

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

Member's Parent/Guardian Name (print clearly):______________________________

Member's Parent/Guardian Signature ______________________________ Date: ___/___/___

To be completed by clinic staff:

Please attest that the patient named above is current on all immunizations as recommended by the current CDC immunization schedule. ☐ Yes ☐ No

Indicate, if any, which immunizations were given during today's visit: ______________________

Clinic staff signature: ______________________________________

Provider's name: ______________________________________
(print)

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

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