Prenatal Program Form

ChildrenFirst
A Good Health Rewards Program
by Community Health Plan of Washington™

Please email completed form to childrenfirst@chpw.org

Congratulations on your pregnancy! As a Community Health Plan of Washington member, **you are eligible to receive a $65 gift card to buy a car seat**. To get your gift card, you must currently be pregnant and see your doctor twice during your pregnancy.

Please bring this form in to your provider or ask your provider at your next visit. You and your provider will fill out the form together, and they will submit it to CHPW for you. **All information regarding the Rewards Program is available at chpw.org/prenatalrewards. If you have any questions about this program, please call Customer Service at 1-800-440-1561 (TTY Relay: Dial 7-1-1), Monday – Friday, 8 a.m. to 5 p.m.**

Member Name: _____

Mailing Address: _____

City/State/Zip: _____ Phone Number: _____

CHPW ID Number: _____ Date of Birth: _____

I request and authorize the disclosure of pregnancy-related protected health information to be released to Community Health Plan of Washington to confirm my eligibility for the Children First Prenatal Program.

Member Signature: _____ Date: ____/_____/_____

This section to be completed by facility staff only

Facility Name: _____

Provider Name: _____
(please print)

Facility Staff Signature: _____

Expected Delivery Date: ____/_____/_____

Date of First Visit: ____/_____/_____

Date of Second Visit: ____/_____/_____

Expecting Multiple Births (twins, etc.)? ☐ Yes ☐ No If yes, please specify: _____

Please send the completed form to: Community Health Plan of Washington
ATTN: Children First Program
By Email: childrenfirst@chpw.org -or-
By Fax: 206-652-7071