

## CONFIRMATION OF PREGNANCY FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to Health Net 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 Health Net Medi-Cal.
- This form must be kept in the patient's medical record.

**Fax to Health Net 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 PPG):									
Member Primary Spoken Language:									
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin <input type="checkbox"/> Farsi <input type="checkbox"/> Korean <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____									

### Pregnancy Information - Required

Date of visit with provider: _____	
Pregnancy diagnosis confirmed: <input type="checkbox"/> Yes  LMP: _____ or EDD: _____	Is this a high-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Rendering Practitioner Information

Practitioner name:					Clinic name:														
Practitioner NPI:					Clinic address:														
<table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>											<input type="checkbox"/> PCP <input type="checkbox"/> NP <input type="checkbox"/> PA								
Office contact name:					City:			County:											
Office phone number:					ZIP code:														
<input type="checkbox"/> I confirm that this document is also filed in the member's legal health/outpatient record.																			
Practitioner signature:					Date signed:														

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