Santa Clara Family Health Plan™

PO Box 18880, San Jose, CA 95158
1.800.260.2055 | TTY 711
www.scfhp.com

MEDI-CAL PRENATAL PROGRAM

Ask your doctor to complete this form and fax it to SCFHP Health Education at **408-874-1959**. Visit www.scfhp.com/healthy-moms-babies for more information and resources.

MEMBER INFORMATION:		
Your Name:		
Birth Date:	**SCFHP ID #:**	
Street Address:		
City:	**State:**	**Zip Code:**
Phone:		
Email:		

DOCTOR INFORMATION:		
Date of Initial Prenatal Checkup:		**Due Date:**
Doctor's Name:		
Clinic Name:		
Clinic Contact:		
Phone #:		**Fax #:**
Visit	**Date of Visit**	**Doctor's Signature**
☐ **Trimester 1**		
☐ **Trimester 2**		
☐ **Trimester 3**		