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PCP Verification of OB-GYN Referral for Medi-Cal Members

Please complete this form to receive your \$50 incentive. Fax a copy to HPSM at (650) 829-2009.

Patient Name: _____ DOB: _____

HPSM Member ID #: _____ Date of visit: _____

This patient is pregnant and has a prenatal appointment with Dr. _____
(OB-GYN)

on _____ Since her EDD is _____, this appointment falls within
(Date) (Date)

her first trimester.

MD Signature

MD Name (Print or stamp)