



Dear New Mother-to-be,

Your doctor has notified us of your pregnancy. We want to give you the support services that you may need in the months ahead.

We want to give you the services that you need to help you and your doctor in having a healthy pregnancy and healthy baby. To help you meet these goals, please remember the following healthy tips:

- Don't smoke during your pregnancy
- Take your prenatal vitamins
- Don't drink alcohol
- Don't take any drugs except on the advice of your physician

Please keep all of your doctor appointments so that your health and the health of your unborn baby can be followed closely.

Enclosed you will find a prenatal reward form. Please keep this form and bring it with you to each doctor visit. If you complete at least 6 visits, as well as the first visit after the birth of your baby, you will be eligible to receive a gift from your health plan --- a new baby stroller.

If you would like more information, please call toll-free 1-800-351-8777 ext. 4038. I am available weekdays 8:00am to 5:00pm EST.

Sincerely,

Judith Tracy, LPN  
Team Leader, OB Case Management

**SUBSTANCE ABUSE HOTLINE**

Florida 1-800-662-4357  
New York 1-800-522-5353  
Connecticut 1-800-203-1234

**DOMESTIC VIOLENCE HOTLINE**

Florida 1-800-500-1119  
New York 1-800-942-6906  
Connecticut 1-888-774-2900

(Si usted necesita mas información sobre el programa en español, favor de llamar a 1-800-351-8777 ext. 4038.)

Enclosure



We want you to join our prenatal program! It's easy. Just have this form signed and dated by your OB doctor at each prenatal visit and at your postpartum check-up. We will send you a new baby stroller absolutely at no charge to you just for going to your prenatal visits and one visit after your delivery.

If you would like more information, please call toll-free 1-800-351-8777 ext. 4038. I am available weekdays 8:00am to 5:00pm EST.

(Si usted necesita más información sobre el programa en español, favor de llamar a 800-351-8777ext: 4038)

(You must complete at least 6 prenatal visits and 1 visit after delivery to be eligible. After your doctor completes this form, please mail it to us or have your doctor fax it to us at 1-877-647-7475).

Your Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Your Address: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**OB Doctors: Please fill in appropriate box below**

Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____
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Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____
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Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____	Date _____ MD Signature _____
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**Visit after Delivery**

Date _____ MD Signature _____
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