

# How to Submit for CHPW ChildrenFirst™ Rewards

As a Community Health Plan of Washington (CHPW) Apple Health (Medicaid) member you can receive free gift cards for prenatal and well-child checkups through our ChildrenFirst™ Program.

- **A \$20 gift card** each time your child goes in for a well-child visit until age 18. That's 27 checkups and 27 gift cards for every child, for a total reward value of up to \$540.
- **A one-time \$65 gift card for a car seat** after two prenatal visits.



To access the Prenatal and Well-Child forms visit this URL:  
**[chpw.org/chpw-benefits-plus/children-first](http://chpw.org/chpw-benefits-plus/children-first)**

## How it works

Here's how members can get the gift cards:



### 1. See the doctor

- ✓ Complete a well-child checkup or complete two prenatal visits during pregnancy.



### 2. Fill out the online reward form

- ✓ **Members can now submit for their rewards.** Clinic staff and provider signatures are no longer required.
- ✓ Go to **[chpw.org/chpw-benefits-plus/children-first](http://chpw.org/chpw-benefits-plus/children-first)**. Select the reward program (Prenatal or Well-Child) and fill out the information requested on the web form. Make sure member has their or their child's CHPW Member ID handy. You will see an approval confirmation and we will send you an email right away if the submission is approved. And remember, members can do this themselves, clinic staff submission and signatures are no longer required.



### 3. Receive the reward by mail

- ✓ Your gift card will be sent to the **mailing address entered on the online form**. Expect the reward within 2-3 weeks.

### Eligibility

To qualify for reward you must:

- Be an active CHPW member on the date you submit the reward request
- Be an active CHPW member on the date of the Well-Child or Prenatal appointment

### Questions?

Call CHPW Customer Service at 1-800-440-1561, Monday through Friday, 8 a.m. – 5 p.m.



## Important tips for filling out online submission form



COMMUNITY HEALTH PLAN  
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- On the first screen, the member's ID, Name, and Date of Birth must match *exactly* what is on the member's CHPW ID card.
- The "Age Group" field refers to the age group found on the well-child visit schedule. There are 27 visits on the schedule and members can get a \$20 gift card every time they go in for a checkup on the schedule. These start at age 2 weeks and go up to member's 18th birthday. The schedule can be found here: <https://www.chpw.org/wp-content/uploads/content/member-center/Well-Child-Checkup-Schedule.pdf>
- One online form must be submitted for each visit. If you are submitting for more than one visit, be sure to fill out a new online form for each visit and appointment date.
- If a mom was a CHPW member and had two or more prenatal visits during her pregnancy but didn't get a \$65 reward through the Prenatal Reward Program, she can get a **one-time \$65 gift card** for a car seat before her child's first birthday. This will replace one of the \$20 Well-Child gift cards. In this case, please supply mom's CHPW member number, in addition to child's member number, when filling out the Well-Child submission form.
- The address entered on the submission form will be the one used for the reward mailing. Remember to report address changes to your plan.
- Members, clinic staff, and providers can fill out the Well-Child submission form.

## Information needed to complete online form

### Well-Child Reward:

\_\_\_\_\_  
Appointment Date

\_\_\_\_\_  
Child's Member ID Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Checkup Age Group

\_\_\_\_\_  
Parent/Guardian First Name

\_\_\_\_\_  
Parent/Guardian Last Name

\_\_\_\_\_  
Phone Number

### Prenatal Reward:

\_\_\_\_\_  
Mother's CHPW Member ID

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Est. Delivery Date

Twins

Triplets

\_\_\_\_\_  
1<sup>st</sup> Prenatal Visit Date

\_\_\_\_\_  
2<sup>nd</sup> Prenatal Visit Date

### Other Information:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State/Zip

\_\_\_\_\_  
Provider First Name

\_\_\_\_\_  
Provider Last Name

\_\_\_\_\_  
Clinic Name

Gift Card Type (choose one):  Amazon  Safeway  Target