

PHYSICIAN'S STATEMENT  
FOR  
**PLANNING FOR HEALTH BABIES (P4HB)**

**Member's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Member's Address:** \_\_\_\_\_  
\_\_\_\_\_

**Member's Telephone Number:** \_\_\_\_\_

**Member ID Number:** \_\_\_\_\_ **Member Case Number:** \_\_\_\_\_

The **Georgia Planning for Healthy Babies** expands the provision of family planning services to uninsured women, ages 18-44, who have family income at or below 200 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible for Medicaid or PeachCare for Kids™.

In addition, **P4HB** provides **Interpregnancy Care (IPC)** services to women who are currently receiving **P4HB** Family Planning and meet all of the following criteria:

1. Is biologically a woman between the ages of 18 – 44      Yes  or No
2. Is fertile and able to become pregnant                      Yes  or No
3. Has delivered:

A very low birth weight (**VLBW**) less than 1500 grams      Yes  or No

This form should be completed and signed by the provider after verifying the member has met the conditions 1 -3 listed above.

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I certify under penalty of perjury that this member's information is true and that she meets the **P4HB** policy regarding **IPC** to the best of my knowledge.

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(Provider's Name)

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(Provider or Authorized Designee's Signature)

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(Provider's ID number)

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(Date)

**Please fax to P4HB at 1-888-744-2102**  
**Questions? Please call 1-877-P4HB101 (744-2101)**