

**ATTENTION SFHP Medi-Cal Members
with Hypertension!**



Get your blood pressure checked by the end of this year.

Members please complete and sign below.

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Birth Date: _____

Telephone: () -

Email: _____

SFHP ID #: _____

My healthy heart action plan (required):

If your blood pressure is at a normal level, what will you do to keep it normal?

If your blood pressure is at a high level, what will you do to make it lower?

Member Signature:
X



San Francisco Health Plan encourages you to get your blood pressure checked regularly to help you and your doctor know if you are at risk for a heart attack or stroke. If you get your blood pressure checked by the end of this year, you can receive a \$25 Walgreens gift card!

Have you gotten your flu shot? The flu can make people with your condition very sick. Protect yourself and others by getting the flu shot. For more information, ask your provider or call Customer Service at **1(800) 288-5555**.

To Claim Your Gift:

- 1** **Make an appointment** with your provider or at your assigned clinic
- 2** **Bring this sheet** with you to your appointment and have your provider or medical assistant sign off that you received your blood pressure check
- 3** **Write down** how you will improve or maintain your current blood pressure level
- 4** **Mail this page** with the signatures and results to San Francisco Health Plan, P.O. Box 194247, San Francisco, CA 94119, or have your clinic fax it to **1(415) 615-4547** as soon as possible after your appointment.

Your PCP is:

Providers please complete and sign.

PCP Name: _____

PCP Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Blood Pressure Check Date: _____

Result: _____

Is this level considered normal? Yes No

Follow-up appointment date (if BP is above normal): _____

Provider Signature:
X

Provider Name:
(Print name if different than above)