Prebirth Selection Form

_____
Today's date

_____ _____
Name of person completing this form | Best phone number to reach you

Member Information

_____ _____
Member (mother) name | Member Medicaid ID number

_____ _____
Member date of birth | Member email address

_____
Member mailing address – Street

_____ _____ _____ _____
Member mailing address – City | State | ZIP Code | Member phone number

Is the mother expecting a multiple birth (twins, triplets, etc.)? ____ Yes ____ No

What is the baby's due date? _____

Newborn Provider Detail *Note to members: Fill in provider name, address, phone info.*

_____ _____
Provider Name | Practice Name, if applicable

_____ _____
Provider NPI | Group NPI, if applicable

_____
Address where newborn will be seen - Street

_____
Address where newborn will be seen – City, State, ZIP Code

_____
Provider Office Phone Number

___ Panel Add **___ Panel Full Add** Approved by Provider

Return this form to:

UnitedHealthcare Community Plan
PO Box 31349
Salt Lake City, UT 84131