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