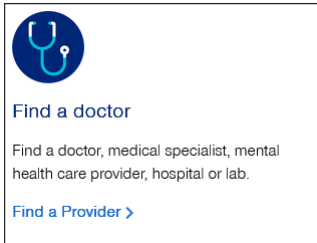


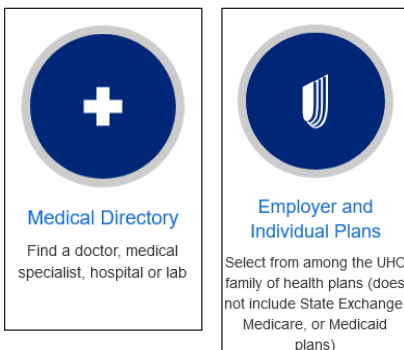


<https://member.uhc.com/myuhc>

1. Click on “Find a Provider”.



2. Click on “Medical Directory”, then click on “Employer and Individual Plans” on the following screen.



3. Next, choose to browse as a UHC member or as a guest by clicking the “Shopping Around” icon.
4. You will now have a list of plans to choose from, listed in alphabetical order.
For HMO plans, choose “SignatureValue Plans”. For PPO plans, choose either “Select Plus”, “Core”, or “Doctors Plan”.

HMO Instructions:

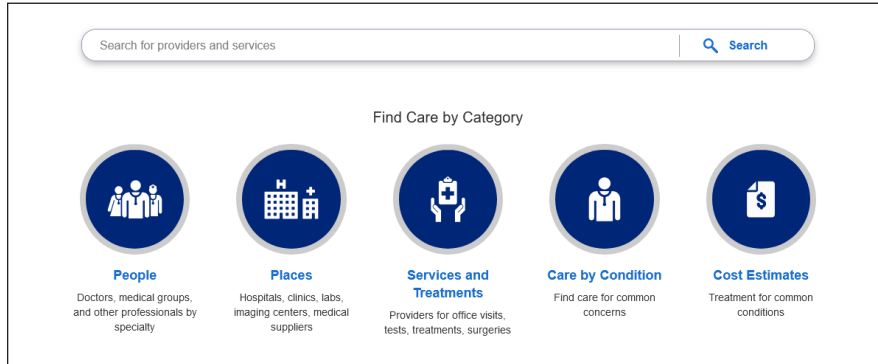
- a. Select California, then choose the appropriate HMO network below:
 - i. **SignatureValue HMO:** Full HMO
 - ii. **Alliance HMO:** Alliance HMO
 - iii. **Harmony HMO:** Harmony HMO
- b. Enter the street address, city & state, or ZIP Code of the provider, then click “Continue”.
You must click “Continue” on the Primary Care Provider information page afterwards.

PPO Instructions:

- a. Select one of the networks below:
 - i. **Select Plus PPO:** Select Plus
 - ii. **Core PPO:** Core
 - iii. **Doctors Plan (PPO):** Doctors Plan
 - iv. **Navigate:** Navigate/Navigate Balanced
- b. When prompted, choose when to receive care.

(continued on next page) 1

4. You can now search by provider, service, or condition. To print a directory, scroll down past the search results and click on the “Print / Email Results” button.



Member Enrollment Application

When completing the Employee Enrollment Application (seen below), you’ll need to provide the Primary Care Physician name and the Provider NPI (National Provider Identifier) number.

A. Employee Information		Complete All Sections If you are waiving coverage, please complete only Sections A and E			
Last Name		First Name		MI	Social Security Number
Address		Apt #	City	State	ZIP Code
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Have you or your dependents ever been a UnitedHealthcare member? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other					
Race/Ethnicity – Check all that apply! <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify					
E-mail address		To select paperless delivery complete and sign the enrollment form and provide your email address. Check here to receive your Required Plan Communications by mail <input type="checkbox"/>			
Primary Care Physician ² Name:		Primary Care Dentist ³ Name:			
Address:		ID#:			
ID#		Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	

