HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

The Good Pregnancy
he hāpai pono

© MEMBER ENROLLMENT FORM ©

Name:__________________________________ Birthdate: _________________ HMSA ID#: ______________________

Mailing Address: ____

Home phone: __________________ Work phone: ___________________ Email address: ___________________________

When is the best time to reach you during the weekday? 7:00am-8:00am 8:00am–12:00pm

12:00pm-2:00pm 2:00pm-5:00pm 5:00pm-6:00pm Other: _______________

Where would you prefer we contact you? At Home At Work Other: ______________________

OB Care Provider's First and Last Name: ____

OB Care Provider's office location:____

OB Care Provider's office phone number:________________________

Your due date:__ __ /__ __ /__ __
m m d d y y

Have you had your first prenatal visit? No Yes - date: __ __/__ __ /__ __
m m d d y y

Member's Signature ____ Date: ___________________________

♥ ♥

Please fax or mail this completed form,
along with Permission to Share Medical Information Form to:

***He Hapai Pono*, 1600 Kapiolani Blvd., Suite 920, Honolulu, HI 96814**
Fax 808.952.4460 © Phone 808.952.4454 or toll-free 888.400.2776