## Blue Cross and Blue Shield of New Mexico Away From Home Care® Program

#### Instructions:

Completion of this Application is not a guarantee of Away From Home Care (AFHC) coverage.

## ALL APPLICATIONS MUST BE "QUALIFIED" FOR COVERAGE UPON RECEIPT BY THE AFHC DEPARTMENT.

- 1. Fill in Guest Member Information, Subscriber Information, and Type of Guest Membership completely. If Guest Member is a Minor, Guardian/Authorized Agent Information must be completed. (AFHC Coordinator will confirm Application Status from/to dates of coverage.)
- Sign, date, and return this application to Blue Cross and Blue Shield of New Mexico (BCBSNM) AFHC Department. For further assistance, contact your Customer Service Department.
- 3. A confirmation letter and a copy of the transmitted Away From Home Care Application will be sent to the Subscriber's address for your records.
- 4. Guest Memberships can be terminated due to lack of eligibility without written notification.
- 5. All Away From Home Care Applications must be renewed prior to Application End Date from/to dates of coverage. BCBSNM AFHC Department will send a courtesy reminder letter 1-2 months prior to the ending date to the Subscriber's home address. It is the Subscriber's responsibility to renew Away From Home Care coverage.
- 6. Please contact the AFHC Department for any changes to this application.
- 7. If retrieving this application from the Web site (www.bcbsnm.com):
  - print
  - complete
  - sign
  - fax to (505) 962-7202, or
  - mail to:

BCBSNM P.O. BOX 27630

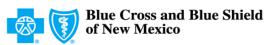
Albuquerque, New Mexico 87125-7630

**ATTN: AFHC FSU** 

Thank you for participating in the HMO Away From Home Care Program.

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# Away From Home Care® Guest Membership Application



Yes/No

Application				
Application UID:	AFHC Network:			
Application Status:	Application Start Date:mm/dd/yyyy		Application End Date: mm/dd/yyyy	
Guest Member Information				
		Date of Birth: _		
Guest Member Name			(mm/dd/yyyy) <b>(Female)</b>	
Away From Home Address: Street/Apt.#				
City State	Zip Code		Number:	
Away From Home Telephone: ( )	-		D:	
Subscriber Information		residuosionip to		
Subscriber information			Employer Information:	
Subscriber Name	Date of Birth:			
Subscriber Address: Street/Apt.#	Gender:	(Male / Female)	Company's Name	
			Company's Address: Street	
City State Zip Code	Social Security Nu	mber:	City State Zip Code	
Primary Telephone: ( ) -				
Work Telephone: ( ) -	Subscriber ID:		Group Number:	
Home Information		Host Information	on	
Plan Code:		Plan Code: _		
Plan Name:		Plan Name:		
Plan Address:		Plan Address:		
Plan Primary Contact/s:				
Plan Primary Contact/s Phone Number: ()	-	Plan Primary 0	Contact/s:	
Home Primary Care Physician:		Plan Primary (	Contact/s Phone Number: () -	
PCP Telephone Number: ( ) -				
Membership Details				
Type of Guest Membership:		Benefit Level:		
( Student / Long-Term Tra	aveler / Families Apart )		( High / Low )	
Drug Card Name:		Drug Card Telephone: () -		
Mental Health Provider Name:		Mental Health Provider Telephone: (		
Mental Health Benefits Provided By:				
Medicare Information				
Medicare Enrollee:				
Guardian/Authorized Agent Information				
Notes:		Telephone: (	) -	
		Relationship to (	ceive information about Guest?	

### **Away From Home Care Application**

I hereby certify that all information stated in Guest Membership and Subscriber Information on the front of this application is truthful and correct to the best of my knowledge. I acknowledge that the benefit program providing coverage to myself or eligible dependents as Guest Members of the Host HMO may vary from the benefit program at my Home HMO. I understand that as a Guest Member the Host HMO benefit program's scope and levels of coverage apply.

Subscriber Signature	Date	
Guest Member Signature	Date	
(Parent/Legal Guardian for Minor)		



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