

Blue Cross and Blue Shield of New Mexico
HMO New Mexico
Guest Membership Program
(Away From Home Care Program)

Instructions:

Completion of this Application is not a guarantee of Guest Membership coverage.

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

1. Fill in sections A, B, and C completely. (AFHC Coordinator will confirm Section C from/to dates of coverage.)
2. Sign, date, and return this application to BCBSNM/HMONM AFHC Department. (See Section D for return address, or for further assistance, contact your Customer Service Department.)
3. A confirmation letter and a copy of the transmitted Guest Membership 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 Guest Membership Applications must be renewed prior to Section C from/to dates of coverage.** BCBSNM/HMONM 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 Guest Membership.
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
 - mail to the address on the application

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

Away From Home Care Guest Services & Follow-up Care Application



Blue Cross and Blue Shield of New Mexico
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company.
HMO New Mexico
Independent Licensees of the Blue Cross and Blue Shield Association.

A. SUBSCRIBER INFORMATION		
Name:	Social security #:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other* *Describe if Other:
Address:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Telephone #:	Date of birth:	
Work telephone #:	Group #:	
Employer name:	Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family
Employer address:		

B. GUEST MEMBER INFORMATION		
Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Social security #:	Guest Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Dependent
Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Medicare Enrollee: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of guardian in area (if applicable):	Date of birth:	Medicare type: <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Risk
Address away from home:		
Telephone away from home:	Drug Carrier Name:	Medicare #:
Should HOST Direct Patient to Medicare Participating Providers? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional information:		

C. CONTROL INFORMATION		
Period of guest membership: <input type="checkbox"/> New <input type="checkbox"/> Renewal	From:	To:
Type of guest membership: <input type="checkbox"/> Families Apart <input type="checkbox"/> Student <input type="checkbox"/> Long-Term Traveler <input type="checkbox"/> Pre-Authorized Follow-Up Care		
MEMO:		

D. HOME HMO INFORMATION	
Name and Address: HMONM/AFHC Department Attn: AFHC Coordinator P.O. Box 11968 "SCB" Albuquerque, NM 87192	HMO CODE: NM1A

Away From Home Care Guest Service & Follow-Up Care Application

I hereby certify that all information stated in Sections A and B 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. (This does not apply to GM, FORD, and Budd members receiving home benefits.)

Subscriber Signature

Date

**Guest Member Signature
(Parent/Legal Guardian for Minor)**

Date