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.)

2. 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.

Away From Home Care® Guest Membership Application

Blue Cross and Blue Shield of New Mexico

Application UID:	**AFHC Network:**

Application Status: **Application Start Date:** _____ (mm/dd/yyyy) **Application End Date:** _____ (mm/dd/yyyy)

Guest Member Information

Guest Member Name

Away From Home Address: Street/Apt.#

City State Zip Code

Away From Home Telephone: ( ) -

Date of Birth: _____ (mm/dd/yyyy)

Gender: **(Male)** _____ **(Female)** _____

Social Security Number: _____

Guest Member ID: _____

Relationship to Subscriber: _____

Subscriber Information

Subscriber Name

Subscriber Address : Street/Apt.#

City State Zip Code

Primary Telephone: ( ) -

Work Telephone: ( ) -

Date of Birth: _____

Gender: _____ (Male / Female)

Social Security Number:

Subscriber ID:

Employer Information:

Company's Name

Company's Address: Street

City State Zip Code

Group Number: _____

Home Information

Plan Code: _____

Plan Name: _____

Plan Address: _____

Plan Primary Contact/s: _____

Plan Primary Contact/s Phone Number: ( ) -

Home Primary Care Physician: _____

PCP Telephone Number: ( ) -

Host Information

Plan Code: _____

Plan Name: _____

Plan Address: _____

Plan Primary Contact/s: _____

Plan Primary Contact/s Phone Number: ( ) -

Membership Details

Type of Guest Membership: _____ (Student / Long-Term Traveler / Families Apart)

Benefit Level: _____ (High / Low)

Memo:

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 Guest: _____

Authorized to receive information about Guest? _____ Yes/No

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
(Parent/Legal Guardian for Minor) **Date**