

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: _____
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Application Status: _____	Application Start Date: _____ mm/dd/yyyy	Application End Date: _____ mm/dd/yyyy
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Guest Member Information

Guest Member Name: _____	Date of Birth: _____ (mm/dd/yyyy)
Away From Home Address: Street/Apt.# _____	Gender: (Male) _____ (Female) _____
City _____ State _____ Zip Code _____	Social Security Number: _____
Away From Home Telephone: () - _____	Guest Member ID: _____
	Relationship to Subscriber: _____

Subscriber Information

Subscriber Name: _____	Date of Birth: _____	Employer Information: _____
Subscriber Address: Street/Apt.# _____	Gender: _____ (Male / Female)	Company's Name: _____
City _____ State _____ Zip Code _____	Social Security Number: _____	Company's Address: Street _____
Primary Telephone: () - _____	Subscriber ID: _____	City _____ State _____ Zip Code _____
Work Telephone: () - _____		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



**Blue Cross and Blue Shield
of New Mexico**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association.