BlueCross BlueShield of New Mexico

# 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 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 the 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. The 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 bcbsnm.com:
   - Print
   - Complete
   - Sign
   - Fax to 312-565-1784
     or
   - Mail to:
     Blue Cross Blue Shield of New Mexico
     ATTN: AFHC FSU
     P.O. Box 660058
     Dallas, TX 75266-0058

BlueCross BlueShield of New Mexico

# Away From Home Care®
# Guest Membership Application

| 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 (INC. AREA CODE) | 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 (INC. AREA CODE) | WORK TELEPHONE (INC. AREA CODE) | DATE OF BIRTH (MM/DD/YYYY) | GENDER ☐ MALE ☐ FEMALE |
| SOCIAL SECURITY NUMBER | SUBSCRIBER ID | | |
| EMPLOYER / COMPANY NAME | EMPLOYER ADDRESS | | |
| CITY | STATE | ZIP | GROUP NUMBER |

## HOME INFORMATION

| PLAN CODE | PLAN NAME |
|---|---|
| PLAN ADDRESS | |
| PLAN PRIMARY CONTACT(S) | |
| PLAN PRIMARY CONTACT(S) PHONE NUMBER (INC. AREA CODE) | |
| HOME PRIMARY CARE PHYSICIAN | |
| PCP TELEPHONE (INC. AREA CODE) | |

## HOST INFORMATION

| PLAN CODE | PLAN NAME |
|---|---|
| PLAN ADDRESS | |
| PLAN PRIMARY CONTACT(S) | |
| PLAN PRIMARY CONTACT(S) PHONE NUMBER (INC. AREA CODE) | |

## MEDICARE INFORMATION

MEDICARE ENROLLEE NAME

## MEMBERSHIP DETAILS

TYPE OF GUEST MEMBERSHIP ☐ STUDENT ☐ LONG-TERM TRAVELER ☐ FAMILIES APART

BENEFIT LEVEL ☐ HIGH ☐ LOW

| DRUG CARD NAME | DRUG CARD TELEPHONE (INC. AREA CODE) |
|---|---|
| MENTAL HEALTH PROVIDER NAME | MENTAL HEALTH PROVIDER TELEPHONE (INC. AREA CODE) |
| MENTAL HEALTH BENEFITS PROVIDED BY | MEMO |

## GUARDIAN/AUTHORIZED AGENT INFORMATION

| NOTES | TELEPHONE (INC. AREA CODE) | RELATIONSHIP TO GUEST | AUTHORIZED TO RECEIVE INFORMATION ABOUT GUEST? ☐ YES ☐ NO |
|---|---|---|---|

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## 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 SIGNED |
|---|---|
| GUEST MEMBER SIGNATURE | DATE SIGNED |