Away From Home Care® Guest Membership Application

BlueCross BlueShield Association

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

I hereby certify that all information stated in the Guest Membership 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 of the Host HMO benefit program's scope and level of coverage apply.

_____ _____

Subscriber Signature Date

I hereby authorize my Home HMO and the Host HMO, identified on the front of this application, to exchange medical information about me.

_____ _____

Guest Member Signature (parent/guardian for minor) Date