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

AFHC NETWORK:
◯ Standard ◯ GMA/UAW
◯ HMO USA ◯ Ford/UAW
◯ Med Blue ◯ Reciprocity

BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans

A - Subscriber Information

APPLICATION DATE:

NAME

SOCIAL SECURITY #

ADDRESS

SEX ◯ Male ◯ Female

MARITAL STATUS ◯ Single ◯ Married ◯ Divorced ◯ Other

TELEPHONE #

WORK TELEPHONE #

DATE OF BIRTH

DESCRIBE OTHER

EMPLOYER NAME

GROUP #

EMPLOYER ADDRESS

TYPE OF COVERAGE	EMPLOYMENT STATUS
◯ Individual ◯ Family	◯ Active ◯ Retired

SUBSCRIBER ID #:

B - Guest Member Information

RELATIONSHIP TO SUBSCRIBER: ◯ Self ◯ Spouse ◯ Dependent

NAME

SOCIAL SECURITY #

ADDRESS AWAY FROM HOME

SEX ◯ Male ◯ Female

GUEST STATUS ◯ Single ◯ Married

TELEPHONE AWAY FROM HOME

DATE OF BIRTH

GUEST MEMBER ID NUMBER

MEDICARE ENROLLEE	MEDICARE TYPE	MEDICARE #	DRUG CARD NAME:
◯ Yes ◯ No	◯ Traditional ◯ Medicare Risk ◯ Medicare Cost	SHOULD HOST DIRECT PATIENT TO PARTICIPATING PROVIDER? MEDICARE ◯ Yes ◯ No	DRUG CARD PHONE:

C - Control Information

PERIOD OF GUEST MEMBERSHIP FROM: ________ TO: ________ ◯ New ◯ Renewal

TYPE OF GUEST MEMBERSHIP

◯ Families Apart ◯ Student ◯ Long term Traveler ◯ Pre-authorized Follow-up Care

BENEFIT LEVEL

◯ High ◯ Low ◯ Medicare

Memo:

D - Home HMO Information

HMO CODE:

NAME AND ADDRESS:

AFHC COORDINATOR

TELEPHONE #

PRIMARY CARE PHYSICIAN

TELEPHONE #

E - Host HMO Information

HMO CODE:

NAME AND ADDRESS:

AFHC COORDINATOR

TELEPHONE #

PRIMARY CARE PHYSICIAN

TELEPHONE #

F - Application Tracking Information

GUEST MEMBERSHIP APPLICATION STATUS:

DATE HOME SENT GMA TO HOST:

DATE HOST RECEIVED GMA FROM HOME:

HOME CONFIRMATION SENT TO MEMBER:

RENEWAL MEMO SEND TO MEMBER:

MEDICAL RECORD REQUESTED:

Please Sign and Return along with enclosed documents.

Away From Home Care Guest Service and 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.)

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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.

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Guest Member Signature (parent/guardian for minor) **Date**

Revised 11/29/04