

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 MARITAL STATUS
 Male Single Married
 Female Divorced Other

TELEPHONE # WORK TELEPHONE #

DATE OF BIRTH DESCRIBE OTHER

EMPLOYER NAME _____

GROUP # _____

EMPLOYER ADDRESS _____

TYPE OF COVERAGE <input type="radio"/> Individual <input type="radio"/> Family	EMPLOYMENT STATUS <input type="radio"/> Active <input type="radio"/> Retired
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SUBSCRIBER ID #: _____

B - Guest Member Information

RELATIONSHIP TO SUBSCRIBER: Self Spouse Dependent

NAME _____

SOCIAL SECURITY # _____

ADDRESS AWAY FROM HOME _____

SEX GUEST STATUS
 Male Single Married
 Female

TELEPHONE AWAY FROM HOME _____

DATE OF BIRTH GUEST MEMBER ID NUMBER

MEDICARE ENROLLEE <input type="radio"/> Yes <input type="radio"/> No	MEDICARE TYPE <input type="radio"/> Traditional <input type="radio"/> Medicare Risk <input type="radio"/> Medicare Cost	MEDICARE # _____	DRUG CARD NAME: _____
SHOULD HOST DIRECT PATIENT TO PARTICIPATING PROVIDER? MEDICARE <input type="radio"/> Yes <input type="radio"/> No		DRUG CARD PHONE: _____	

C - Control Information

PERIOD OF GUEST MEMBERSHIP FROM: _____ TO: _____ New Renewal

TYPE OF GUEST MEMBERSHIP BENEFIT LEVEL
 Families Apart Student Long term Traveler Pre-authorized Follow-up Care High Low Medicare

Memo: _____

D - Home HMO Information

E - Host HMO Information

HMO CODE: _____

HMO CODE: _____

NAME AND ADDRESS: _____

NAME AND ADDRESS: _____

AFHC COORDINATOR TELEPHONE # _____

AFHC COORDINATOR TELEPHONE # _____

PRIMARY CARE PHYSICIAN TELEPHONE # _____

PRIMARY CARE PHYSICIAN TELEPHONE # _____

F - Application Tracking Information

GUEST MEMBERSHIP APPLICATION STATUS: _____

HOME CONFIRMATION SENT TO MEMBER: _____

DATE HOME SENT GMA TO HOST: _____

RENEWAL MEMO SEND TO MEMBER: _____

DATE HOST RECEIVED GMA FROM HOME: _____

MEDICAL RECORD REQUESTED: _____

G -AWAY FROM HOME CARE AUTHORIZATION

I hereby certify that all information stated in Sections A and B on 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 benefits program's scope and levels of coverage apply.

Signature of Subscriber

Date

I hereby authorize my Home HMO and my Host HMO to exchange medical information about me.

Signature of Guest Member (parent/guardian for minor)

Date

Upon receipt and acceptance of this application, a confirmation letter will be sent to you with a copy of the completed application for your files. Guest membership coverage is typically effective 15 days after the Guest Membership application is received by the Away From Home Care Coordinator.

You may mail the completed application to:

BlueChoice HealthPlan
ATTN: AFHC Coordinator - AX-435
PO Box 6170
Columbia, SC 29260-6170

You also may fax the completed application to:

BlueChoice HealthPlan
Away From Home Care Coordinator
803-714-6443