BlueCross BlueShield of Texas

Blue Cross and Blue Shield of Texas 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 bcbstx.com:
   - Print
   - Complete
   - Sign
   - Fax to 312-565-1784
     or
   - Mail to:
     Blue Cross Blue Shield of Texas
     ATTN: AFHC FSU
     P.O. Box 660044
     Dallas, TX 75266-0044

BlueCross BlueShield of Texas

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		HOST INFORMATION	
PLAN CODE	PLAN NAME	PLAN CODE	PLAN NAME
PLAN ADDRESS		PLAN ADDRESS	
PLAN PRIMARY CONTACT(S)		PLAN PRIMARY CONTACT(S)	
PLAN PRIMARY CONTACT(S) PHONE NUMBER (INC. AREA CODE)		PLAN PRIMARY CONTACT(S) PHONE NUMBER (INC. AREA CODE)	
HOME PRIMARY CARE PHYSICIAN			
		MEDICARE INFORMATION	
PCP TELEPHONE (INC. AREA CODE)		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