Away from Home Care Guest Membership Application

BlueCross BlueShield Association

Guest Member Information

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Name: _____ Social Security #: _____

Away From Home Address: _____ Gender:

_____ ☐ Male ☐ Female

(**Mailing Address Must Be Complete)**

City: _____ State: _____ Zip: _____ Date of Birth: _____

Away from Home Telephone #: _____

Medicare Enrollee:
☐ Yes
☐ No

Medicare Type:
☐ Traditional
☐ Medicare Risk
☐ Medicare Cost

Medicare #: _____

Should host direct patient to a Medicare Participating Provider?
☐ Yes ☐ No

Type of Guest Membership

Student Families Apart Long Term Traveler

Subscriber Information

Name: _____ Social Security #: _____

Address: _____ Gender:

City: _____ State: _____ Zip: _____ ☐ Male ☐ Female

Home Telephone #: _____ Date of Birth: _____

Work Telephone #: _____ Subscriber ID #: _____

Cellular Telephone #: _____ Group #: _____

Employer Name: _____ Employee Status:

Employer Address: _____ ☐ Active ☐ Retired

City: _____ State: _____ Zip: _____ Type of Coverage:

☐ Individual ☐ Family

Requested Dates for Guest Membership:

From: _____

To: _____

Comments/Additional Requests: _____

HMO ILLINOIS

I hereby verify that all information stated 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 General Motors members receiving home benefits). I hereby authorize the Host Plan to disclose information regarding Guest Membership information to the Care Giver.

_____ _____

Subscriber Signature Date

If you would like confirmation upon receipt of your application, please provide an email address where you would like the confirmation sent.

Email Address:

_____

If the Guest Member is under the age of 18, a Care Giver's name must be entered here. A Standard Authorization to Use or Disclose Protected Health Information (PHI) Form is required at the time of enrollment into the program.

_____

Care Giver Name

Away from Home Care Guest Membership Application -- SAMPLE

BlueCross BlueShield Association

Guest Member Information **- Complete this box with the information about the person who will be going out of state and using the Guest Membership policy**

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Name: _____ Social Security #: _____

Away From Home Address: _____ Gender:

_____ ☐ Male ☐ Female

(**Mailing Address Must Be Complete**)

City: _____ State: _____ Zip: _____ Date of Birth: _____

Away from Home Telephone #: _____

Medicare Enrollee:
☐ Yes
☐ No

Medicare Type:
☐ Traditional
☐ Medicare Risk
☐ Medicare Cost

Medicare #: _____

Should host direct patient to a Medicare Participating Provider?
☐ Yes ☐ No

Type of Guest Membership **– Select the appropriate type of Guest policy (see next page for explanation)**

Student Families Apart Long Term Traveler

Subscriber Information **– Complete this box with the information about the policy holder of the BCBS HMO IL policy**

Name: _____ Social Security #: _____

Address: _____ Gender:

City: _____ State: _____ Zip: _____ ☐ Male ☐ Female

Home Telephone #: _____ Date of Birth: _____

Work Telephone #: _____ Subscriber ID #: _____

Cellular Telephone #: _____ Group #: _____

Employer Name: _____ Employee Status:

Employer Address: _____ ☐ Active ☐ Retired

City: _____ State: _____ Zip: _____ Type of Coverage:

☐ Individual ☐ Family

Requested Dates for Guest Membership:

Enter the dates you are requesting the guest membership policy for

From: _____

To: _____

Comments/Additional Requests: _____

HMO ILLINOIS

I hereby verify that all information stated 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 General Motors members receiving home benefits). I hereby authorize the Host Plan to disclose information regarding Guest Membership information to the Care Giver.

Please have the subscriber sign and date here

_____ _____

Subscriber Signature Date

If you would like confirmation upon receipt of your application, please provide an email address where you would like it sent.

Email Address: **Enter email address**

_____

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Application -- SAMPLE

If the Guest Member is under the age of 18, a Care Giver's name must be entered here. A Standard Authorization to Use or Disclose Protected Health Information (PHI) Form is required at the time of enrollment into the program.

Provide the name of the caregiver for a minor who is the guest member and complete the Standard Authorization Form (SAF)

Care Giver Name

Email Address: afhcd@bcbsil.com Fax Number: 312.565.1784 Revised 10/2014

Type of Guest Membership

Student – Check this option if you are applying for guest membership due to being away at school

Families Apart – Check this option if you reside in another state, not with the subscriber of the HMOIL policy.

Long-Term Traveler - Check this option if you will be traveling for more the 90 days out of state and then returning home to IL within 180 days. After 180 days, a new Guest Membership Application is required.