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 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

Form Updated 03/2013

*Older versions of this application will no longer be accepted as 06/2013

Email Address: afhcd@bcbsil.com
Fax Number: 312.565.1784