

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 benefits 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.)

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.

Guest Member Signature
(parent/guardian for minor)

Date

**** OUT OF STATE GUARDIAN NAME AND ADDRESS FOR DEPENDENTS UNDER AGE 18****

FAX 1-866-755-5283

1-800-535-8291 / 8 AM – 5:30 PM Weekdays / www.bcbsga.com
P.O. Box 7368 Attn: Guest Membership – Columbus, GA 31908-7368

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