AmeriHealth NEW JERSEY

Health insurance that pays.SM

Please complete both sides of this application and submit using one of the following methods:

- **Email a scanned copy to**
  guestadvantageahnj@amerihealth.com
- **Mail a paper copy to:**
  AmeriHealth New Jersey
  259 Prospect Plains Road, Bldg M
  Cranbury, NJ 08512

Guest Advantage™ Application

A. Subscriber Information

Subscriber's Name (First, Middle, Last)		Subscriber's Member ID	
Present Street Address	City	State	Zip Code
Home Telephone Number	Marital Status	Sex ☐ Male ☐ Female	Birth Date ___/___/____
Type of Coverage (check one) ☐ Individual ☐ Employer			
Employer Name (if applicable)			
Employer Address	City	State	Zip Code
Employment Status (check one) ☐ Active ☐ Retired			

B. Guest Information

Guest's Name (First, Middle, Last)		Guest's Member ID	
Permanent Street Address (check if same as subscriber) ☐	City	State	Zip Code
Out-of-Area Street Address (check if same as subscriber) ☐	City	State	Zip Code

Dates Guest Expected to Reside Out-of-Area

First day at out-of-area address: ____ /____ /____ Last day at out-of-area address: ____ /____ /____

Are there any pending services that have already been granted prior authorization in area, but won't have been performed by the date the member officially begins residing out-of-area? (First day at out of area address noted above)

☐ Yes (please describe):_____ ☐ No, no services have been authorized as noted above

Note: Members outside of the AmeriHealth New Jersey service area are responsible for obtaining precertification (see reverse).

Type of Guest Advantage (reason for out-of-area address)

☐ Student (temporary student address). Must submit transcript.

☐ Short Term Work Traveler (temporary work address). Must submit letter from employer on employer letterhead.

☐ Families Apart (subscriber and dependent live apart - subscriber court-ordered to provide benefits). Must submit court order.

Guest Advantage℠ Guest Service Application

I request participation in the Guest Advantage program offered by AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey ("AmeriHealth New Jersey") in the applicable benefit contract. I understand that, in order to be considered for enrollment in the program by the date requested, I should apply no less than 30 days prior to my first day outside the AmeriHealth New Jersey service area.

I acknowledge that the benefit program providing coverage to myself or eligible dependents as members of the Guest Advantage program may vary from the in-network benefits I may access through AmeriHealth New Jersey. I understand that I will need to precertify certain services in accordance with the materials provided to me from AmeriHealth New Jersey. I understand and agree that if I do not receive precertification from AmeriHealth New Jersey for the services required to be precertified that I will be liable for some or all of the costs of the unauthorized medical care I receive.

I understand that I may remain enrolled in Guest Advantage for no longer than one year. I understand that I must re-apply for extensions. I understand that Guest Advantage will cover out-of area dependents if mandated by court order/agreement. I understand that proof must be provided for all applicants.

I understand that I need to remain in the MultiPlan network in order to receive the out-of-area coverage provided by the Guest Advantage program. I understand that my coverage automatically reverts to my home area on a pre-defined date set by me and the plan at the time of application/enrollment. I understand that it is my responsibility to notify AmeriHealth New Jersey if I return home sooner than documented. I understand that I must utilize AmeriHealth New Jersey service area providers if I return home temporarily. I understand that I must notify AmeriHealth New Jersey in advance if I wish to use out-of-network benefits while under Guest Advantage.

Because Primary Care Physicians can give advice and provide recommendations about health care services that I may need while traveling, I understand that I am encouraged to receive routine care or planned care prior to leaving home.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

I hereby certify that all information stated in this application is truthful and correct to the best of my knowledge.

_____ _____

Subscriber Signature Date

_____ _____

Guest Advantage Member Signature Date

(Parent/Guardian for Minor)

COMPANY USE ONLY

Type of Guest Advantage (check one) Families Apart ☐ Student ☐ Short Term Work Traveler ☐

New/Renewal (circle one)

Period of Guest Advantage _____ to _____

Effective date _____

Reason for denial _____

Has supporting documentation been provided? Yes ☐ No ☐ If yes, describe_____

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