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 ___/___/____
Employer Name (if applicable)			
Employer Address	City	State	Zip Code

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 (Students must provide academic year start and end dates)
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 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 current 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.**

* All fields are required

Guest Advantage is not available to Consumer, Government Markets, Self-Funded customers, or employees of a group offering a National Access plan.

Covered Persons who enroll in the Guest Advantage Program must utilize Providers who are located within forty-five (45) miles of the temporary address supplied in this application.

Guest Advantage™ Application

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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NEW JERSEY

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Language Taglines and Nondiscrimination Notice

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh. Hódíílnih koji̜' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

(OVER)

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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