Horizon

Horizon Blue Cross Blue Shield of New Jersey

CONVERSION REQUEST FORM

(one form per product change)

Group Name: _____

Group Number: _____

Effective Date: _____ Renewal Date (Internal Use Only): _____

Broker Name: _____ Vendor Number: _____

If census is changing, please include enrollment forms for new employees and/or any contract changes for existing members.

Please provide employee name and selected Primary Care Physician (if applicable).

Employee Name	**PCP (if applicable)** (J or K codes only)	**Current Subgroup #** (Internal Use Only)	**New Subgroup #** (Internal Use Only)

**** Please note that unless notified, all groups will be set up for one bill option.***
***** Please submit quote with the Conversion Request Form.***

Comments: _____

_____

_____

_____

Group Signature: _____ Date: _____

Account Consultant Signature: _____ Date: _____

An independent licensee of the Blue Cross and Blue Shield Association.