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: ______________________________

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Group Signature: ______________________________ Date: ____________

Account Consultant Signature: ______________________________ Date: ____________

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