

Ancillary / Hospital Fee Schedule Requisition

Applicable to BCBSTX Contracted Physicians and Providers Only

* Indicates a required field

**National Provider
Identifier (NPI) Number(s):** _____

* **Provider Name:** _____

* **Primary Specialty:** _____

* **Provider Address:** _____

* **City / State / Zip:** _____

* **County:** _____

* **Provider Phone Number:** _____

* **Contact Name:** _____

* **Contact Phone Number:** _____

* **Contact Fax:** _____

* **Contact E-mail:** _____

* **Product:** HMO Blue[®] Texas

BlueChoice[®]

ParPlan

* **Fee Schedule Effective Date:** _____

Fax Your Fee Request To:

713.663.1250

Your request should be completed within 30 days. Please contact your local Network Representative if you have not received your request within the allotted timeframe.

Updated 05-2008