BlueCross BlueShield of Texas

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: **972.766.1103**

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.

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