

Ancillary / Hospital Fee Schedule Request Form

Applicable to BCBSTX Contracted Providers Only

* Indicates a required field

*National Provider				
Identifier(s) (NPI):				
* Provider Name:				
* Primary Specialty:				
* Provider Address:				
* City / State / Zip:				
* County:				
*Provider Phone Number:				
*Contact Name:				
*Contact Phone Number:				
* Contact Fax:				
* Contact E-mail:				
SELECT PLAN(S):				
Blue Advantage HMO SM		Blue P	remier ^{sм}	
Blue Choice PPO SM		MyBlue	MyBlue Health SM	
Blue Essentials SM		ParPla	ParPlan	
Blue High Performance Network SM				
* Fee Schedule Effective Date:				

Refer to the Contact Us page on the Provider Website for email addresses to submit your request:

- Ancillary providers refer to *Ancillary Network Management* based on your specialty.
- Hospital providers refer to your Network Management Office Location.

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