BlueCross BlueShield of Texas

TX OFFICE BASED PROVIDER FACILITY COVERAGE LETTER

To: **Blue Cross and Blue Shield of Texas**

Date: _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network facility (in applicable BCBSTX provider network(s) in which I participate), except for medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSTX subscriber/member care to a participating physician or hospitalist (in the applicable BCBSTX provider network) who has active admitting privileges at a participating network facility (in the applicable BCBSTX provider network).

Provider's Name: _____

Provider's NPI #: _____

Provider's Signature: _____

Please Note:

- *The only providers permitted to submit a signed "Facility Coverage Letter" for facility admitting privileges' requirement can be found at:*

  https://www.bcbstx.com/docs/provider/tx/network/credentialing/types-prof-providers-req-cred.pdf

- *If you are unsure of the participation status in a specific BCBSTX provider network, for yourself, another physician, hospitalist, or facility, refer to* ***Provider Finder ®.***

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