Blue Choice Physician
Nomination Form

Name of Provider: _____

Address: _____

City, State & Zip: _____

Specialty (Circle One): **Family Practice**

Internal Medicine

Pediatric

Obstetrician/Gynecologist

Other _____

Your Name: _____

This is strictly a nomination form. We cannot guarantee physician participation. Blue Cross and Blue Shield of Texas network representatives will contact your provider regarding the Blue Choice program. If your physician is interested, he/she may apply to become a Blue Choice provider and undergo the standard credentialing process.

After you complete this form, please return it to:

Mail: **BlueCross BlueShield of Texas**
Major/National Accounts
901 South Central Expressway
North Building B
Richardson, TX 75080
Attention: Siri Spradling

OR

FAX: 972-766-4983, Attention: Siri Spradling

OR

E-mail: Siri_Spradling@bcbstx.com