

HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield of Texas (BCBSTX)

Date: _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in applicable BCBSTX provider network(s) in which I participate), with the exception of 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 hospital (in the applicable BCBSTX provider network).

(Please print legibly)

Provider's Name: _____

Provider's NPI #: _____

Provider's Signature: ______

Please Note:

- The only providers permitted to submit a signed "Hospital Coverage Letter" for hospital privileges' requirement, are the following provider specialties/types: Adolescent Medicine, Child & Adolescent Psychiatry, Developmental-Behavioral Pediatrics, Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Pediatrics, Physical Medicine & Rehabilitation, Preventive Medicine, and Psychiatry.
- If you are unsure of the participation status in a specific BCBSTX provider network, for yourself, another physician, hospitalist, or hospital, please contact your BCBSTX Network Management office by fax or phone.

BCBSTX Network Management Office	FAX Number	Telephone Number
Austin	512-349-4853	512-349-4847
Corpus Christi	361-852-0624	361-878-1623
Dallas	972-766-2231	972-766-8900 / 800-749-0966
El Paso	915-496-6614	915-496-6600
Houston, Beaumont, East Texas	713-663-1227	713-663-1149 / 800-637-0171
Lubbock, Amarillo	806-783-4666	806-783-4610
Midland, Abilene, San Angelo	432-620-1428	432-620-1406
San Antonio	361-852-0624	361-878-1623

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