BlueCross BlueShield of Texas

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℠	☐	Blue Premier℠
☐	Blue Choice PPO℠	☐	MyBlue Health℠
☐	Blue Essentials℠	☐	ParPlan
☐	Blue High Performance Network℠		

* 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.

Updated 08-2021