



**BlueCross BlueShield
of Texas**

HOSPITAL REFERRAL LETTER

To: Blue Cross Blue Shield of Texas Date: _____

Please accept this correspondence as confirmation that since I do not have privileges at a HMO/Blue Choice network hospital, with the exception of medical emergencies, my practice will be confined to outpatient.

If non-emergency hospitalization is necessary, I will refer care to a HMO/Blue Choice network provider that has active admitting privileges at a participating HMO/Blue Choice network facility.

Provider's name (please print)

Provider's signature

Name of Designated Admitting Network Physician HMO PPO

NPI # of above Designated Admitting Network Physician

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Note: If you are unsure of the network status of providers and/or hospitals, please contact your local Blue Cross Blue Shield of Texas office.

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