BlueCross BlueShield of Texas

ANCILLARY PROVIDER ID REQUEST FORM

Date: _____

Email: TXFPS@bcbstx.com
Attn: Facility Provider Services

<table>
<tr><td colspan="2">Provider of Service Information:
Corporate Name (line 1 of W-9)</td><td colspan="4">Address: Physical/Place of Practice:
Address</td><td>Suite</td></tr>
<tr><td colspan="2">DBA Name (line 2 of W-9)</td><td>City</td><td>State</td><td>Zip</td><td>County</td></tr>
<tr><td colspan="2">Type of Facility, Product or Services</td><td colspan="4">Phone Number ( ) -

Fax Number ( ) -</td></tr>
<tr><td>Medicare #</td><td>NPI</td><td colspan="4">Email Address</td></tr>
<tr><td colspan="2">Tax I.D Information:</td><td colspan="4">Address: Payee Address/Mail Check To:</td></tr>
<tr><td colspan="2">Federal Tax Id Number</td><td colspan="3">Address</td><td>Suite</td></tr>
<tr><td colspan="2" rowspan="3">Complete only if adding an Affiliate location to a Parent Hospital. Check one of the following:

☐ Provider has been deemed “Provider Based Status” meaning it is operationally integrated with a main hospital and operates under the same name, ownership and administrative and financial control of a main hospital including license and NPI.

☐ Provider has NOT been deemed “Provider based Status” but is required by BCBSTX to be wholly owned, has its own license and NPI and is within 35 miles of the acute care hospital. Credentialing is required.</td><td>City</td><td>State</td><td>Zip</td><td>County</td></tr>
<tr><td colspan="4">Phone Number ( ) -

Fax Number ( ) -</td></tr>
<tr><td colspan="4">Email Address</td></tr>
</table>

To the best of my knowledge, the information supplied on this document is accurate and complete, and is hereby released to Blue Cross and Blue Shield of Texas for the purpose of establishing a BCBSTX provider ID for claims processing.

Signature of Applicant or Authorized Representative

X_____

Signature

Title _____ **Date** **MM / DD / YY**

ATTACH A COPY OF:

☐ **Facility license issued by your State or the license for your Product or Services.**

☐ **W-9 form signed and dated.**

☐ **NPI Confirmation.**

This is a form to establish an Out-of-Network provider ID for Blue Cross and Blue Shield of Texas. This form does not indicate participation in any Networks. After a Provider ID is established you will receive a confirmation letter. Thank you.