BlueCross BlueShield of Texas

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