



## Fee Schedule Request Form

**Please complete the information below to request a fee schedule or allowances for specific codes. An email address is required in the space below if requesting a complete fee schedule. Attach a list of codes, if applicable.**

Date \_\_\_\_\_

### Physician/Provider Information

Name	BCBSF Number	National Provider Identifier (NPI)	
Mailing Address	City	State	Zip
Street Address	City	State	Zip
Telephone Number ( )	Fax Number ( )		
Email (required to obtain a complete schedule)			
Contact Name			

### Product Lines

(You may only receive allowance information for those products for which you have a fully executed contract.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All contracted product lines | <input type="checkbox"/> Medicare Advantage HMO | <input type="checkbox"/> Preferred Patient Care (PPC) |
| <input type="checkbox"/> Advantage65                  | <input type="checkbox"/> Medicare Advantage PPO | <input type="checkbox"/> Traditional/PPS              |
| <input type="checkbox"/> BlueSelect                   | <input type="checkbox"/> Miami-Dade Blue        |   |
| <input type="checkbox"/> Health Options               | <input type="checkbox"/> NetworkBlue            |   |

### Physician or Provider Signature Required for Release of Information

Provider Name \_\_\_\_\_ Provider Signature \_\_\_\_\_  
(please print)

Provider Title \_\_\_\_\_

**Note:** This form is for Blue Cross and Blue Shield of Florida contracted physicians and providers only.

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