



Fee Schedule Request Form

To obtain the Current Procedural Terminology (CPT®) code fee schedule, complete and send this form to Blue Cross and Blue Shield of New Mexico by:

- Fax to 1-866-290-7718, or locally at 505-816-2688 or
- Email to FeeScheduleRequests@bcbsnm.com

You will receive an email from BCBSNM with the requested information.

Requester name and title:		Date:	
Provider Name:			
NPI Number:		Tax ID Number:	
Address:			
City:		State	ZIP
Phone Number:		Fax Number:	
Email Address:			
Requested Networks: <input type="checkbox"/> Commercial (HMO, PPO, POS, PAR, FEP) <input type="checkbox"/> Blue Community SM HMO <input type="checkbox"/> Blue Advantage HMO Network SM Blue Preferred SM Network			
Medicaid Fee Schedules (Human Services Department website) Medicare Physician Fee Schedule Look-Up Tool (CMS website)			
Additional instructions, specific code requests, etc.:			

See next page for Confidentiality Agreement. This must be completed, signed, and returned to BCBSNM by both contracted and non-contracted providers prior to receiving fee schedule information. By completing and submitting this Form, you are representing that Provider has signed and returned the Confidentiality Agreement and that you are authorized pursuant thereto to receive the Schedule(s) Thank you.

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CONFIDENTIALITY AGREEMENT

Effective as of the date on which the last party signs, this Confidentiality Agreement (“Agreement”) is entered into between Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (“BCBSNM”) and _____ (“Provider”).

WHEREAS, BCBSNM and Provider are in the process of good faith negotiations regarding Provider’s possible participation or continued participation in one or more of the BCBSNM network(s); and

WHEREAS, Provider has requested the opportunity to review BCBSNM’s provider reimbursement schedule(s) applicable to one or more of BCBSNM’s networks in order to assist in its evaluation of such participation; and

WHEREAS, BCBSNM has advised Provider of the highly confidential and proprietary nature of BCBSNM’s Schedules but is agreeable to disclosing one or more of the Schedule(s) subject to the terms and conditions hereinafter set forth;

NOW THEREFORE, the parties hereto agree as follows:

1. BCBSNM shall disclose to Provider, upon submission of a completed Fee Schedule Request Form and BCBSNM’s determination that Provider is making a bona fide, good faith request, a copy of the applicable Schedule(s) or those parts thereof as pertinent to Provider’s area of practice.
2. Provider agrees and acknowledges that each Schedule is highly confidential and proprietary information of BCBSNM. Provider agrees that such information shall be disclosed only to those persons employed by Provider who are responsible for the final decision as to whether or not to participate in the BCBSNM network(s) and are prior informed of and agree with Provider to abide by the terms of this Confidentiality Agreement.
3. Provider agrees that it will not give, disclose, sell, or transfer to others, or cause or permit to be given, disclosed, sold, or transferred to others any Schedule, or any part thereof, or use or permit to be used such information for other than the purposes herein above described.
4. Provider agrees that no copies of any Schedule or any part thereof will be made or disclosed other than for the purposes discussed herein without the express prior written authorization of BCBSNM.
5. This Confidentiality Agreement shall be binding and the obligations arising under the Confidentiality Agreement will continue in the event that Provider does not participate or does not continue to participate in BCBSNM’s network(s), the Schedule(s) therefor and all copies thereof shall be destroyed by Provider at such time.
6. Any agreement between the parties to maintain the confidentiality of any Schedule(s) that predates this Confidentiality Agreement remains in full force and effect as to any Schedule(s) disclosed pursuant thereto. Furthermore, this Confidentiality Agreement supplements any other confidentiality obligations that may exist between the parties, such that in the event of a conflict, the provisions that are more protective of the Schedule(s) shall control.

Name of Provider: _____

NPI Number: _____

By: _____

Title: _____

Signature: _____

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO,
A DIVISION OF HEALTH CARE SERVICE
CORPORATION, A MUTUAL LEGAL RESERVE
COMPANY

By: _____

Title: _____