BlueCross BlueShield of Montana

HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield **Date:** _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a BCBSMT participating network hospital, with the exception of medical emergencies, my practice will be confined to outpatient services.

If non-emergency hospitalization is necessary, I will refer care to, and help coordinate with, a BCBSMT participating network practitioner that has active admitting privileges at a participating network facility.

Practitioner's Name: _____
(please print name legibly)

Practitioner's Signature: _____

DESIGNATED PRACTITIONER(S):

Name of Designated Admitting Network Practitioner:

_____
(please print name legibly)

Name of Designated Admitting Network Practitioner:

_____
(please print name legibly)

If Designated Admitting Practitioner is a Hospitalist, please provide the name of the Hospitalist Group and their Group Tax Identification Number below:

Name of Hospitalist Group: _____
(please print name legibly)

Hospitalist Group Tax ID: _____
(please print name legibly)

Note: If you are unsure of the network status of a practitioner and/or a hospital, please contact your local Blue Cross and Blue Shield Network Management office.