



**Blue Cross and Blue Shield  
of New Mexico**

## Fee Schedule Request Form

**Attention: CPT Fee Schedule Requests**

Fax this form toll-free to Blue Cross and Blue Shield of New Mexico at 1-866-290-7718, or locally to 816-2688 to obtain the CPT code fee schedule.

**Attention:**

**Date:**

**Provider Name**

**NPI Number**

**Address**

**City**

**State and ZIP**

**Telephone Number**

**Fax Number**

**E-mail Address**


**How would you like to receive the Fee Schedule?**

- Copy of entire Fee Schedule on CD (Microsoft Excel spreadsheet)
- E-mail Fee Schedule (Microsoft Excel spreadsheet) Note: Must indicate e-mail address above.
- Top 10 Specialty codes and E&M only

**See next page for Confidentiality Agreement. This must be completed by both contracted and non-contracted providers prior to receiving fee schedule information. Thank you.**

# CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement (“Agreement”) is entered between Health Care Service Corporation, a Mutual Legal Reserve Company, and its divisions and affiliates including but not limited to Blue Cross and Blue Shield of New Mexico (“BCBSNM”) (referred to collectively as “HCSC”) and \_\_\_\_\_ (“Provider”).

WHEREAS, HCSC and Provider are in the process of good faith negotiations toward the end of Provider agreeing to participate or continue to participate in BCBSNM network; and

WHEREAS, Provider has requested the opportunity to review BCBSNM’s Schedule of Maximum Allowances in order to assist in its final determination as whether Provider will agree to participate or continue to participate in the BCBCNM network; and

WHEREAS, HCSC has advised Provider of the highly confidential and proprietary nature of BCBSNM’s Schedule of Maximum Allowances but is agreeable to disclosing the Schedule of Maximum Allowances 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 their National Provider Identification number (NPI), a copy of the Schedule of Maximum Allowances (the “Schedule”) or those parts thereof as pertinent to Provider’s area of practice.
2. Provider agrees and acknowledges that the Schedule is highly confidential and proprietary information of BCBSNM. Provider agrees that such information shall be disclosed only to those individuals at Provider’s facility responsible for the final decision as to whether or not to participate in the BCBSNM network.
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 the 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 the 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 decides not to participate or not to continue to participate in BCBSNM’s network, the Schedule of Maximum Allowances and all copies thereof shall be destroyed at such time.

HEALTH CARE SERVICE CORPORATION, A  
MUTUAL LEGAL RESERVE COMPANY

By: \_\_\_\_\_  
Title: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

NPI Number: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Authorized Representative: \_\_\_\_\_

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