



## Fee Schedule Request Form—BlueChoice (POS)

Attention: PTC Fee Schedule Requests

Fax this form to Blue Cross and Blue Shield of Illinois at 1-618-997-9480 to obtain the CPT code fee schedule for BlueChoice (POS).

Provider Name:	
NPI Number:	
Attention:	
Address:	
City:	
State:	
Zip:	
Telephone Number:	
Fax Number:	
E-mail Address:	
Date:	

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

- Copy of Fee Schedule on CD (Microsoft Excel spreadsheet)
- E-mail Fee Schedule (Microsoft Excel spreadsheet) Note: Must indicate e-mail address above.

See the next page for the Confidentiality Agreement.

**CONFIDENTIALITY AGREEMENT**

This Confidentiality Agreement (“Agreement”) is entered between Health Care Service Corporation, a Mutual Legal Reserve Company (“HCSC”) and \_\_\_\_\_.

WHEREAS, HCSC and \_\_\_\_\_ are in the process of good faith negotiations toward the end of \_\_\_\_\_’s agreeing to <<continue to>> participate in the HCSC <<BlueChoice>> network; and

WHEREAS, \_\_\_\_\_ has requested the opportunity to review HCSC’s << BlueChoice >> Schedule of Maximum Allowances in order to assist in its final determination as whether \_\_\_\_\_ will agree to <<continue to>> participate in the HCSC << BlueChoice >> network; and

WHEREAS, HCSC has advised \_\_\_\_\_ of the highly confidential and proprietary nature of HCSC’s << BlueChoice >> Schedule of Maximum Allowances but is agreeable to disclosing the << BlueChoice >> Schedule of Maximum Allowances subject to the terms and conditions hereinafter set forth;

NOW THEREFORE, the parties hereto agree as follows:

1. HCSC shall disclose to \_\_\_\_\_, upon submission of their BCBSIL Blue Shield number, a copy of the << BlueChoice >> Schedule of Maximum Allowances (the “Schedule”) or those parts thereof as pertinent to \_\_\_\_\_’s areas of practice.
2. \_\_\_\_\_ agrees and acknowledges that the Schedule is highly confidential and proprietary information of HCSC. \_\_\_\_\_ agrees that such information shall be disclosed only to those individuals at \_\_\_\_\_ responsible for the final decision as to whether or not to participate in the HCSC << BlueChoice >> network.
3. \_\_\_\_\_ 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. \_\_\_\_\_ 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 HCSC.
5. This Confidentiality Agreement shall be binding and the obligations arising under the Confidentiality Agreement will continue in the event that \_\_\_\_\_ decides not to <<continue to>> participate in HCSC’s << BlueChoice >> 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, (“HCSC”)

\_\_\_\_\_  
*Name of Provider*

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

NPI Number: \_\_\_\_\_  
By: \_\_\_\_\_  
Title: \_\_\_\_\_  
Authorized Representative:  
\_\_\_\_\_