

# PROVIDER NOMINATION FORM

*Instructions to Employee:*

**Please mail or fax this nomination form to your campus benefit office or to:**

BCBSTX  
Attention: Teresa Smith  
4002 Loop 322  
Abilene, TX 79602  
Fax Number: 325-793-4234

## PROVIDER INFORMATION

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

**Specialty:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
(Include Area Code)

## MEMBER INFORMATION

**Your Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_  
(Include Area Code)

**Please check the plan for which you are nominating this provider.**

\_\_\_\_\_ BlueCross BlueShield (PPO)

\_\_\_\_\_ HMO Blue Texas