



**FIRST PRACTICE LOCATION**

NAME OF FACILITY			
STREET ADDRESS			CITY
PARISH	STATE	ZIP CODE	EMAIL
PHONE NUMBER ( )	FAX NUMBER ( )	TAX IDENTIFICATION NUMBER	
FACILITY PERSON			NPI NUMBER
BILLING ADDRESS: (if different from above)			CITY
PARISH	STATE	ZIP CODE	EMAIL
PHONE NUMBER ( )	FAX NUMBER ( )	CONTACT PERSON	

**SECOND PRACTICE LOCATION**

**If more than two locations, please attach a separate listing.**

NAME OF FACILITY			
STREET ADDRESS			CITY
PARISH	STATE	ZIP CODE	EMAIL
PHONE NUMBER ( )	FAX NUMBER ( )	TAX IDENTIFICATION NUMBER	
FACILITY PERSON			
BILLING ADDRESS: (if different from above)			CITY
PARISH	STATE	ZIP CODE	EMAIL
PHONE NUMBER ( )	FAX NUMBER ( )	CONTACT PERSON	

**ORGANIZATION SPECIALTY**

<input type="checkbox"/> Ambulance Services	<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> DME	<input type="checkbox"/> Hospice	<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Skilled Nursing Facility (Free Standing)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Rehabilitation Center (Physical) (Free Standing)	<input type="checkbox"/> Radiology (Diagnostic) <input type="checkbox"/> Diagnostic Imaging <input type="checkbox"/> PETS
<input type="checkbox"/> Urgent Care Clinic/Walk-In Clinic	<input type="checkbox"/> Alcohol/Drug Reheilitation Center (CDU)	<input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility	<input type="checkbox"/> Lithotripter Facility	<input type="checkbox"/> Infusion Therapy Provider
<input type="checkbox"/> Radiation Center (Free Standing)	<input type="checkbox"/> Charity – Acute Care Hospital	<input type="checkbox"/> Outpatient Cardiac Catherization Facility	<input type="checkbox"/> Sleep Disorder Clinic/Lab	<input type="checkbox"/> Federally Qualified Rural Health Clinic
<input type="checkbox"/> Psychiatric Hospitals	<input type="checkbox"/> Long Term Acute Care Facility	<input type="checkbox"/> Renal Dialysis Center	<input type="checkbox"/> State Owned Psychiatric Hospital	<input type="checkbox"/> Psychiatric Hospital (Free Standing)
<input type="checkbox"/> Intensive Outpatient Program	<input type="checkbox"/> Partial Hospitalization Program	<input type="checkbox"/> Residential Treatment Center	<input type="checkbox"/> CDU (Free Standing)	<input type="checkbox"/> Other _____

## GENERAL BUSINESS INFORMATION

Beginning Date of Operation / /	Ownership Name
Type of Ownership: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation Other, Please Explain:	
Administrator Name	Phone Number ( )

## ACCREDITATION INFORMATION

Is your organization approved by one of the below national accrediting bodies?  Yes  No  
**If yes, please indicate one or more of the following and submit a copy of accreditation letter or certificate:**  
If pending, please indicate the date of survey or application date: \_\_\_/\_\_\_/\_\_\_

AAHC Accreditation <input type="checkbox"/> Yes <input type="checkbox"/> No	CHAP Accreditation <input type="checkbox"/> Yes <input type="checkbox"/> No
AASM Accreditation <input type="checkbox"/> Yes <input type="checkbox"/> No	JCAHO Accreditation <input type="checkbox"/> Yes <input type="checkbox"/> No

Other: \_\_\_\_\_

Were there any deficiencies from your last survey?  Yes  No  
**If so, please attach an explanation and your action plan to address recommendations.** Effective Date \_\_\_/\_\_\_/\_\_\_  
Have deficiencies been removed?  Yes  No Effective Date \_\_\_/\_\_\_/\_\_\_

## LICENSE AND MEDICARE INFORMATION

State License Number: \_\_\_\_\_

**Please indicate one or more of the following and submit a copy of license:**

<input type="checkbox"/> State of LA DHH License	<input type="checkbox"/> CLIA Certificate	<input type="checkbox"/> DEQ Certificate
<input type="checkbox"/> Occupational License	<input type="checkbox"/> Operational License	

Do you participate in Medicare?  Yes  No  
**If yes, please complete the following and submit a copy of letter:**  
Medicare Number: \_\_\_\_\_ Effective Date of Participation: \_\_\_/\_\_\_/\_\_\_

Were there any deficiencies from your last survey?  Yes  No  
**If yes, please attach an explanation and your action plan to address recommendations.**  
Have deficiencies been removed?  Yes  No Effective Date \_\_\_/\_\_\_/\_\_\_

## PROFESSIONAL LIABILITY INSURANCE COVERAGE INFORMATION

Name of Carrier

Policy Number	Expiration Date ___/___/___
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Amounts Per Incident/Aggregate for Professional Liability Coverage

Do you participate in the Louisiana Patients' Compensation Fund?  Yes  No  
**Please submit a copy of the Certificate of Insurance and LPCF Certificate, as applicable. All insurance certificates must include the name and address of the requesting facility, not the ownership corporation.**

## STATEMENT TO APPLICANTS

All organizations applying for network participation have the right to review information obtained by Blue Cross and Blue Shield of Louisiana to evaluate their credentialing application. The only exception to this policy is information that we are prohibited by law from releasing.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have 10 days to submit additional information to correct the discrepancy or provide clarification that may positively impact the credentialing decision.

**PLEASE SUBMIT COPIES OF THE FOLLOWING DOCUMENTS WITH THIS APPLICATION IF APPLICABLE TO YOUR PROVIDER TYPE**

- Accrediting entity certification (JCAHO, CHAP, etc.)
- License (State, Occupational, CLIA, etc.)
- Medicare Participation Letter (if applicable)
- Professional Liability Insurance Certificate
- Louisiana Patients' Compensation Fund Certificate (if applicable)
- List of Top 10 CPT Codes billed for your facility
- If your organization is an ambulance company, please complete attachment A.
- If your organization is a DME supplier, please complete attachment B.
- If your organization is a Hospital or Ambulatory Surgical Center, please complete attachment C.
- If your organization is an Urgent Care/Walk-In Clinic, please complete attachment D
- EIN Letter

**Mail application and documents to:**

**Network Operations Department  
Blue Cross and Blue Shield of Louisiana  
P.O. Box 98029  
Baton Rouge, LA 70898-9029**

**Any questions? Call 1-800-716-2299 – Option 3.**

**HEALTH DELIVERY ORGANIZATION STATEMENT OF ATTESTATION**

I hereby affirm that the information furnished by me is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatements in, or omissions from, this application, whether intentional or not, shall constitute cause for summary dismissal as a Blue Cross and Blue Shield of Louisiana (BCBSLA) provider. In the event that participation privileges have been granted prior to such misstatement or omission, such discovery may result in termination from BCBSLA.

I agree that I have a continuing affirmative duty to inform BCBSLA immediately of any material changes that may affect my organization's status. I consent to the release of all information that may be relevant to an evaluation of my organization's credentials, including information about disciplinary actions or other confidential or privileged information, to BCBSLA or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which my organization participates as a BCBSLA provider. I release BCBSLA, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my organization's credentials.

I submit this application in the expectation that confidentiality and privacy will be preserved, and that the information will be used only for credentialing, peer review, and quality assurance activities.

\_\_\_\_\_  
**Facility Name**

**X**  
\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Title**