HEALTH DELIVERY ORGANIZATION INFORMATION FORM, ATTACHMENT A- AMBULANCE COMPANY

Please complete this form and attach to the Health Delivery Organization Form if your organization is an Ambulance Company.

GENERAL INFORMATION

NAME OF AMBULANCE COMPANY

CONTACT PERSON	PHONE NUMBER	FAX NUMBER

Is your organization licensed to provide:

❑ Air ❑ ALS ❑ BLS ❑ Intermediate

Do you provide non-emergency transportation?

❑ Yes ❑ No

Please list the parishes/service area that your company services.

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Do you use 911 in your response area for receiving calls?

❑ Yes ❑ No

If no, please provide the telephone number(s) you use to receive emergency calls. If more than one number is used, please provide each number and the corresponding service area.

Phone Number	**Service Area**
____________	______________________________
____________	______________________________
____________	______________________________

SERVICE CLASSIFICATION

❑ EMS Div. ❑ Fire ❑ Government ❑ Hospital ❑ Paid

❑ Police ❑ Private ❑ Volunteer ❑ Other____________

FUNDING/MEMBERSHIP

Describe how your ambulance service is funded.

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What percentage of your revenue is subsidized through taxes? ____________

What is the source of the subsidy? ______________________________

Are you required to provide specified services?

❑ Yes ❑ No

If yes, please explain: ______________________________

What percentage of your revenue is subsidized through taxes? ______________________

Do you have a membership program?

❑ Yes ❑ No

If yes, what does your membership fee cover? Is the member responsible for the portion not covered by insurance?

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____

If no, is the patient responsible for the portion not covered by insurance or is payment in full required at the time services are provided? ____

If you have a membership program, is the patient's insurer billed the same amount as a patient without a membership?

❑ Yes ❑ No

If no, please provide your policy: ____

Does your membership contract permit you to bill Medicare, Medicaid and/or private insurers?

❑ Yes ❑ No

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

Mail the Health Delivery Organization Information Form and Attachment A to:

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