HEALTH DELIVERY ORGANIZATION INFORMATION FORM, ATTACHMENT C- HOSPITAL OR AMBULATORY SURGICAL CENTER

Please complete this form and attach to the Health Delivery Organization Form if your organization is a Hospital or Ambulatory Surgical Center.

GENERAL INFORMATION

NAME OF HOSPITAL OR AMBULATORY SURGICAL CENTER

GENERAL BUSINESS INFORMATION

TYPE OF OWNERSHIP

❑ Chain ❑ Federal ❑ Hospital ❑ Non-profit ❑ Proprietary ❑ State

Proprietary/chain organization ______

Name (as registered with the IRS): ______

And address: ______

THIS FACILITY IS LICENSED TO PROVIDE SERVICES FOR:

❑ General acute care Bed size ______	❑ Ambulatory surgery
❑ Long-term acute care Bed size ______	❑ Diagnostic evaluation
❑ Psychiatric Bed size ______	❑ Home health
❑ Rehabilitation Bed size ______	❑ Hospice
❑ Skilled nursing Bed size ______	❑ Radiation therapy
❑ Substance abuse Bed size ______	❑ Other ______
❑ Alcohol/Drug Rehabilitation Center (CDU) Bed size ______	
❑ Special Care Unit – Behavior Modification Bed size ______	

AMBULATORY SURGICAL FACILITY (FREE-STANDING)

MEDICARE NUMBER	OFFICIAL NAME OF UNIT	
TYPE UNIT: ❑ Hospital-based ❑ Free-standing	DO YOU HAVE MULTIPLE OPERATING SUITES? ❑ Yes ❑ No	ARE THE MAJORITY OF THE PROCEDURES PERFORMED UNDER GENERAL ANESTHESIA? ❑ Yes ❑ No
DO YOU HAVE A TRANSFER AGREEMENT WITH A LOCAL HOSPITAL? ❑ Yes ❑ No (If yes, please attach a copy of transfer agreement.)		ARE FACILITY FEES BILLED AS: ❑ Single unit charge procedure ❑ Itemized line item charge
IS THERE A PROFESSIONAL FEE INCLUDED IN THE CHARGE STRUCTURE NOTED ABOVE? ❑ Yes ❑ No		ARE M.D. AND ANESTHESIOLOGY FEES BILLED BY YOUR FACILITY? ❑ Yes ❑ No

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE

CHEMICAL DEPENDENCY AND PSYCHIATRIC UNIT

MEDICARE NUMBER	OFFICIAL NAME OF UNIT		
TYPE UNIT: ❑ Hospital-based – inpatient ❑ Hospital-based – outpatient	❑ Free-standing - inpatient ❑ Free-standing - outpatient	TYPE OF TREATMENT: ❑ Alcohol recovery ❑ Substance abuse	LEVEL OF TREATMENT ❑ Adult ❑ Adolescent ❑ Partial hospitalization
WHAT IS THE AVERAGE LENGTH OF STAY?	WHAT IS THE AVERAGE CHARGE PER ADMISSION?	ARE UNIT POLICIES AND PROCEDURES APPROVED BY STATE LICENSING ENTITY? ❑ Yes ❑ No	

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company
(Over)

ARE PROFESSIONAL COMPONENTS FOR SERVICES RENDERED IN THE UNIT INCLUDED IN THE DAILY FACILITY CHARGE?

❑ Yes ❑ No

IF NO, HOW ARE THESE CHARGES BILLED?

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

HOME HEALTH

MEDICARE NUMBER	OFFICIAL NAME OF UNIT

TYPE UNIT:

❑ Hospital-based ❑ Free-standing

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

HOSPICE

OFFICIAL NAME OF UNIT	TYPE UNIT: ❑ Hospital-based – inpatient ❑ Free-standing ❑ Hospital-based - outpatient

IS THE PROGRAM DESIGNED TO TREAT THE TERMINALLY ILL PATIENT DURING THE FIRST STAGES OF TERMINAL ILLNESS?

ARE PATIENTS ADMITTED TO THE PROGRAM ONLY WHEN LIFE EXPECTANCY IS SIX MONTHS OR LESS?

IS TREATMENT PROVIDED BY A TEAM OF TRAINED MEDICAL PERSONNEL WHO ACT UNDER AN INDEPENDENT, LEGALLY LICENSED HOSPICE ADMINISTRATION?

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

REHABILITATION UNIT

MEDICARE NUMBER	OFFICIAL NAME OF UNIT

TYPE UNIT:

❑ Hospital-based ❑ Free-standing

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SKILLED NURSING UNIT

MEDICARE NUMBER	OFFICIAL NAME OF UNIT

TYPE UNIT:

❑ Hospital-based ❑ Free-standing

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

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

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