



Please complete this form and attach to the Health Delivery Organization Form if your organization is an Urgent Care Clinic/Walk-In Clinic.

GENERAL INFORMATION

NAME OF CLINIC

BUSINESS INFORMATION

HOURS OF OPERATION:

Sunday _____ am _____ pm

Monday _____ am _____ pm

Tuesday _____ am _____ pm

Wednesday _____ am _____ pm

Thursday _____ am _____ pm

Friday _____ am _____ pm

Saturday _____ am _____ pm

DO YOU OFFER APPOINTMENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO YOU PROVIDE URGENT AND MINOR EMERGENCY CARE TO PATIENTS ON AN UNSCHEDULED BASIS? <input type="checkbox"/> Yes <input type="checkbox"/> No
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DO YOU OFFER FOLLOW-UP CARE OR WELLNESS EXAMINATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No	ARE PATIENTS REFERRED TO THEIR PRIMARY PHYSICIAN FOR ROUTINE FOLLOW-UP AND WELLNESS CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No
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ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

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

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