



Please complete this form and attach to the Health Delivery Organization Form if your organization is a free-standing (non-hospital based) Diagnostic Radiology facility.

FACILITY NAME INFORMATION

NAME OF FACILITY _____

BCBSLA PROVIDER NUMBER _____

FACILITY NPI NUMBER _____

TIN NUMBER _____

GENERAL BUSINESS INFORMATION

TYPE OF OWNERSHIP (Check all that applies; List all owners, if jointly owned by more than one party.)

Physician Owned (Non-Radiologist) Physician Owned (Radiologist) Chain* Federal Hospital State

Other* (*please explain below)

Please explain *Other Ownership: _____

Please explain *Chain Ownership: _____

Please list the percentage of ownership for each category _____

*If your facility is physician owned, please list the name of the physicians included in the ownership arrangement below and their percentage of ownership:

Who is providing supervisor of each test? _____

Does the supervising physician provide supervision of at any other facility? Yes No; If yes, identify the facility name, address, TIN and level of supervision provided. _____

DIAGNOSTIC RADIOLOGY SERVICES (FREE-STANDING)

Does this facility bill globally for all services, i.e. both the technical and professional component combined?

If yes, identify the providers performing services for the professional interpretations at your facility.

If no, identify the radiologist(s)/group contracted by your facility to perform the professional interpretations.

Please list the name & specialty of the facility's full-time Medical Director below. Include a telephone number to contact the full-time Medical Director.

Is the Medical Director board certified? If so, list specialty.

Does the Medical Director:

Assume responsibility for the overall direction & control of the quality of testing performed?

Assume responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications?

Assume responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures?

If not, provide the name, specialty and telephone number of the physician who assumes these responsibilities.

SERVICES RENDERED AND ACCREDITATION

PLEASE INDICATE THE SERVICES THAT THIS FACILITY CURRENTLY PROVIDES:

- | | |
|--------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Computerized Tomography Angiography | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Computerized Tomography Scans | <input type="checkbox"/> Positron-Emission Tomography Scans |
| <input type="checkbox"/> Magnetic Resonance Angiography | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Magnetic Resonance Imaging | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Mammography
Digital? Yes or No | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Fluoroscopy | <input type="checkbox"/> Total Modalities offered _____ |

PLEASE INDICATE WHICH SERVICES LISTED ABOVE ARE ACCREDITED:

- Joint Commission **Services:** _____
- American College of Radiology **Services:** _____
- Intersocietal Accreditation Commission **Services:** _____
- Other Accreditation: _____

*Effective 1/1/2010, BCBSLA requires all free-standing diagnostic radiology facilities to be accredited for all modalities they perform services for by either ACR or IAC.

PLEASE INDICATE THE PAYOR CATEGORIES THAT THIS FACILITY SERVICES:

- Medicare
- Charity Care (Uncompensated Care)
- Medicaid
- Private Pay (Non-Insured)
- Commercial Insurance
- TriCare

If you do not accept Federally funded patients, why not? _____

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 _____

Name of person completing this form _____

Title of person completing this form _____

Date form is completed : _____

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

ATTACH A COPY OF THE FACILITY'S LICENSE, ACCREDITATION, MALPRACTICE INSURANCE DECLARATION PAGE AND EIN LETTER. ALSO, ATTACH A DESCRIPTION OF THE TYPE OF EQUIPMENT INCLUDING MODEL NUMBER AND CERTIFICATION USED IN THE FACILITY. FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DELAYED CREDENTIALING PROCESSING.

Mail the Health Delivery Organization Information Form, Attachment E & Requested Supporting Documentation to:

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

Questions completing this form? Call 1-800-716-2299, Option 2