BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Medicare Advantage Member Servicing
Confirmation Form

In completing this Member Servicing Confirmation, I agree to provide medical services to the Blue Cross and/or Blue Shield Medicare Advantage member designated below and to be reimbursed for those services at the rate identified.

Please return this Member Servicing Confirmation to Blue Cross and Blue Shield of Louisiana Network Administration via fax to (225) 297-2750 or via e-mail to network.administration@bcbsla.com.

Member Information

Member Name: ____

Member Address: ____

Member Identification Number: ____

Other Information: ____

Duration: (Please select one of the following)

_______ End date: ________________

_______ For the treatment or care of the following condition: ________________________

_______ Until I notify Blue Cross and Blue Shield of Louisiana at the fax number or e-mail address above

Provider Information

Provider Name: ____

Provider Location: ____

Provider Telephone Number: ____

Provider Identification Number: ____

NPI Number: ____

Other Information: ____

Reimbursement Rate = Medicare Allowable Amount, less member-owed deductibles, copayments, or co-insurance.

Provider Signature: ____________________________ Date Issued: ________________