Louisiana

Add Practice Location Form

Complete this form when an individual provider is adding a practice location(s). You must include a copy of the Malpractice Liability Insurance Certificate for the physical location you are adding. If you are linking to a provider group or clinic, you must fully complete the Link to Group of Clinic Request form.

GENERAL INFORMATION

Individual Provider Last Name	First Name	Middle Initial

Individual Provider NPI	Languages Spoken
Group/Clinic Name	Group/Clinic NPI
Group/Clinic Tax ID Number	Effective Date
What is your specialty?	Are you a primary care provider (PCP)? ☐ Yes ☐ No

LOCATION TO BE ADDED

Physical Address

City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date

Accepting New Patients	Age Range of Patients (check all that apply)
☐ New ☐ Existing Only	☐ 0-6 years ☐ 7-11 years ☐ 12-18 years
☐ Other: _____	☐ 19-65 years ☐ Over 65 ☐ All Ages
	☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

LOCATION TO BE ADDED

Physical Address

City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date

Accepting New Patients	Age Range of Patients (check all that apply)
☐ New ☐ Existing Only	☐ 0-6 years ☐ 7-11 years ☐ 12-18 years
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	☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

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LOCATION TO BE ADDED

Physical Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

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CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ This form is fully completed, including the effective date of addition(s)
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ This form is signed and dated
- ☐ Only if a new group or clinic is not already on file with Blue Cross, complete an iLinkBlue agreement packet (available online at www.BCBSLA.com/providers >Electronic Services >iLinkBlue)

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative	Date
Contact Email Address	Contact Phone Number

Return Form To:

Email: network.administration@bcbsla.com

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: (225) 297-2750

Phone: 1-800-716-2299, option 3