Louisiana

Link to Group or Clinic Request Form

Complete this form when an individual provider is linking to a provider group or clinic. You must include a copy of the Malpractice Liability Insurance Certificate for the physical location you are linking to. If you are linking to a new provider group or clinic that is not already set up with Blue Cross, please also fully complete and include the iLinkBlue agreement packet (includes an electronic funds transfer application); available online at www.BCBSLA.com/providers >Electronic Services >iLinkBlue. **To link to more than two physical locations, make a copy of page 2 of this 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

BILLING ADDRESS (for payment registers, reimbursement checks, etc.)

Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

18NW2375 R02/18

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

PHYSICAL ADDRESS

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

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

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

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

PHYSICAL ADDRESS

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

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

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

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

CHECKLIST

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

- ☐ This form is fully completed, including the effective date of link
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ This form is signed and dated
- ☐ Only if a new group or clinic not already on file with Blue Cross, a completed iLinkBlue agreement packet is included (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