Health Delivery Organization Information Form, Attachment A - Ambulance Company

Please complete this form and attach to the Health Delivery Organization Form if your organization is an Ambulance Company.

GENERAL INFORMATION

Name of Ambulance Company

Contact Person	Phone Number	Fax Number

Is your organization licensed to provide:
☐ Air ☐ ALS ☐ BLS ☐ Intermediate

Do you provide non-emergency transportation?
☐ Yes ☐ No

Please list the parishes/service area that your company services

Do you use 911 in your response area for receiving calls?
☐ Yes ☐ No

If no, please provide the telephone number(s) you use to receive emergency calls. If more than one number is used, please provide each number and the corresponding service area.

Phone Number	Service Area
____________	____________
____________	____________
____________	____________

SERVICE CLASSIFICATION

☐ EMS Div. ☐ Fire ☐ Government ☐ Hospital ☐ Paid
☐ Police ☐ Private ☐ Volunteer ☐ Other (please specify):

FUNDING/MEMBERSHIP

Describe how your ambulance service is funded

What percentage of your revenue is subsidized through taxes?	What is the source of the subsidy?

Are you required to provide specified services?
☐ Yes ☐ No
If yes, please explain: ____________

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.

Do you have a membership program?

☐ Yes ☐ No

If yes, what does your membership fee cover? Is the member responsible for the portion not covered by insurance?

If no, is the patient responsible for the portion not covered by insurance or is payment in full required at the time services are provided?

If you have a membership program, is the patient's insurer billed the same amount as a patient without a membership?

☐ Yes ☐ No If no, please provide your policy: ______________________________

Does your membership contract permit you to bill Medicare, Medicaid and/or private insurers?

☐ Yes ☐ No

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

Return application and documents to:

Email: network.administration@bcbsla.com Fax: (225) 297-2750

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