Louisiana

Health Delivery Organization Information Form, Attachment C - Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility

Please complete this form and attach to the Health Delivery Organization Form if your organization is a Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility. Check and complete only the sections that apply.

GENERAL INFORMATION

Name of Hospital, Ambulatory Surgical Center or Free-standing Nursing Facility

GENERAL BUSINESS INFORMATION

Type of Ownership

☐ Chain ☐ Federal ☐ Hospital ☐ Non-profit ☐ Proprietary ☐ State

Proprietary/chain Organization

Name (as registered with IRS)

Address	City	State	ZIP Code

This facility is licensed to provide services for:

☐ General acute care	Bed size: _____	☐ Ambulatory surgery	
☐ Long-term acute care	Bed size: _____	☐ Diagnostic evaluation	
☐ Psychiatric	Bed size: _____	☐ Home health	
☐ Rehabilitation	Bed size: _____	☐ Hospice	
☐ Skilled nursing	Bed size: _____	☐ Radiation therapy	
☐ Special Care Unit – Behavior Modification	Bed size: _____	☐ Other: _____	

Are professional components for services rendered in the unit included in the daily facility charge?

☐ Yes ☐ No

If no, how are these charges billed? _____

AMBULATORY SURGICAL FACILITY (FREE-STANDING)

Medicare Number	Official Name of Unit

Type Unit:

☐ Hospital-based ☐ Free-standing

Do you have multiple operating suites?

☐ Yes ☐ No

Are the majority of the procedures performed under general anesthesia?

☐ Yes ☐ No

Do you have a transfer agreement with a local hospital?

☐ Yes ☐ No *If yes, please attach a copy of transfer agreement.*

Are facility fees billed as:

☐ Single unit charge procedure ☐ Itemized line item charge

Is there a professional fee included in the charge structure noted above?

☐ Yes ☐ No

Are M.D. and anesthesiology fees billed by your facility?

☐ Yes ☐ No

Attach a copy of your facility's state license, if applicable

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INTENSIVE OUTPATIENT PROGRAM OR PARTIAL HOSPITAL PROGRAM

Please indicate which national behavioral health organization you are contracted with for Intensive Outpatient Program services or Partial Hospital Program services.

- ☐ Magellan Behavioral Health — Date Contracted
- ☐ United Behavioral Health – United Healthcare — Date Contracted
- ☐ LifeSynch – Humana — Date Contracted
- ☐ CIGNA Behavioral Health — Date Contracted
- ☐ Aetna Behavioral Health — Date Contracted
- ☐ Value Options — Date Contracted

CHEMICAL DEPENDENCY UNIT

Medicare Number	Official Name of Unit

Type Unit:	Type of Treatment:	Level of Treatment
☐ Hospital-based – inpatient ☐ Free-standing – inpatient ☐ Hospital-based – outpatient ☐ Free-standing – outpatient	☐ Alcohol recovery ☐ Substance abuse	☐ Adult ☐ Adolescent ☐ Partial hospitalization

What is the average length of stay?	What is the average charge per admission?

Are unit policies and procedures approved by state licensing entity?
☐ Yes ☐ No

PSYCHIATRIC UNIT

Medicare Number	Official Name of Unit

Type Unit:	Type of Treatment:	Level of Treatment
☐ Hospital-based – inpatient ☐ Free-standing – inpatient ☐ Hospital-based – outpatient ☐ Free-standing – outpatient	☐ Alcohol recovery ☐ Substance abuse	☐ Adult ☐ Adolescent ☐ Partial hospitalization

What is the average length of stay?	What is the average charge per admission?

Are unit policies and procedures approved by state licensing entity?
☐ Yes ☐ No

HOME HEALTH

Medicare Number	Official Name of Unit

Type Unit:
☐ Hospital-based ☐ Free-standing

HOSPICE

Official Name of Unit

Type Unit:
☐ Hospital-based – inpatient ☐ Hospital-based – outpatient ☐ Free-standing

Is the program designed to treat the terminally ill patient during the first stages of terminal illness?

Are patients admitted to the program only when life expectancy is six months or less?

Is treatment provided by a team of trained medical personnel who act under an independent, legally licensed hospice administration?

Attach a copy of your facility's state license, if applicable

REHABILITATION UNIT	
Medicare Number	Official Name of Unit
Type Unit: ☐ Hospital-based	☐ Free-standing

SKILLED NURSING UNIT	
Medicare Number	Official Name of Unit
Type Unit: ☐ Hospital-based	☐ Free-standing

Attach a copy of your facility's state license, if applicable

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