Louisiana

Health Delivery Organization Information Form, Attachment F - Retail Health Clinics

Please complete this form and attach to the Health Delivery Organization Form if your organization is a Retail Health Clinic.

FACILITY NAME INFORMATION	
Name of Facility	
Medicare Provider Number	Facility NPI Number
Medicaid Provider Number	TIN Number

GENERAL BUSINESS INFORMATION	
Type of Ownership (Check all that apply. List all owners, if jointly owned by more than one party.)	
☐ Physician Owned	☐ Federal
☐ Chain* (please explain below)	☐ Hospital
☐ Other* (please explain below)	☐ State
Please explain *Chain Ownership	
Please explain *Other Ownership	
Please list the percentage of ownership for each category	
*If your facility is physician owned, please list the name of the physicians included in the ownership arrangement below and their percentage of ownership	

MEDICAL DIRECTOR AFFILIATION
Please list the name, phone number & specialty of the facility's Medical Director:
How often does he/she work on-site at the clinic?
Is the Medical Director board certified? ☐ Yes ☐ No *If yes, list board certification specialty:* _____

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.

PLEASE INDICATE THE SERVICES THAT THIS FACILITY CURRENTLY PROVIDES

Common Illnesses

- ☐ Allergies
- ☐ Bladder Infections
- ☐ Bronchitis
- ☐ Ear Infections
- ☐ Pink Eye
- ☐ Sinus Infections
- ☐ Strep Throat
- ☐ Swimmers Ear

Skin Conditions

- ☐ Athlete's Foot
- ☐ Cold Sores
- ☐ Deer Tick Bites
- ☐ Impetigo
- ☐ Minor Burns
- ☐ Minor Skin Infections & Rashes
- ☐ Minor Sunburn
- ☐ Poison Ivy
- ☐ Ringworm
- ☐ Singles Treatment
- ☐ Wart Removal

Vaccines

- ☐ Diphtheria, Tetanus, Pertussis
- ☐ Flu (Seasonal)
- ☐ Hepatitis A & B
- ☐ Meningitis
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Pneumonia
- ☐ Polio (IPV)

Wellness & Prevention

- ☐ Camp Physicals
- ☐ Cholesterol Screening
- ☐ Comprehensive Health Screening
- ☐ Diabetes Screening
- ☐ Hypertension Screening
- ☐ Obesity Screening

Additional Services

- ☐ Ear Wax Removal
- ☐ Flu Diagnosis
- ☐ Mononucleosis
- ☐ Pregnancy Testing
- ☐ Suture Removal
- ☐ Other:

STATEMENT OF ATTESTATION

I hereby affirm that the information furnished by me is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatements in, or omissions from, this application, whether intentional or not, shall constitute cause for summary dismissal as a Blue Cross and Blue Shield of Louisiana (BCBSLA) provider. In the event that participation privileges have been granted prior to such misstatement or omission, such discovery may result in termination from BCBSLA.

I agree that I have a continuing affirmative duty to inform BCBSLA immediately of any material changes that may affect my organization's status. I consent to the release of all information that may be relevant to an evaluation of my organization's credentials, including information about disciplinary actions or other confidential or privileged information, to BCBSLA or its affiliates or successors.

I understand and agree that this consent is irrevocable for any period during which my organization participates as a BCBSLA provider.

I release BCBSLA, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my organization's credentials.

I submit this application in the expectation that confidentiality and privacy will be preserved, and that the information will be used only for credentialing, peer review, and quality assurance activities.

Facility Name	
Name of person completing this form	Title of person completing this form
Date form is completed	

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

Attach a copy of the

- facility's occupational or operational license
- malpractice insurance declaration page
- EIN letter

Failure to provide this information will result in delayed credentialing processing.

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