



Please complete this form and attach to the Health Delivery Organization Form if your organization is an Outpatient Cath Lab.

GENERAL INFORMATION	
Name of Outpatient Cath Lab	
GENERAL BUSINESS INFORMATION	
Type of Ownership <input type="checkbox"/> Chain <input type="checkbox"/> Federal <input type="checkbox"/> Hospital <input type="checkbox"/> Non-profit <input type="checkbox"/> Proprietary <input type="checkbox"/> State	
Proprietary/chain Organization	
Name (as registered with the IRS)	Address
Are professional components for services rendered in the unit included in the daily facility charge? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how are these charges billed? _____	
OUTPATIENT CATH LAB (FREE-STANDING)	
Medicare Number	Official Name of Unit
Type Unit: <input type="checkbox"/> Hospital-based <input type="checkbox"/> Free-standing	Do you have multiple operating suites? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are the majority of the procedures performed under general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a transfer agreement with a local hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please attach a copy of transfer agreement.</i>	
Are facility fees billed as: <input type="checkbox"/> Single unit charge procedure <input type="checkbox"/> Itemized line item charge	
Is there a professional fee included in the charge structure noted above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are M.D. and anesthesiology fees billed by your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the facility submit data to the ACC-National Cardiovascular Data Registry for CATHPCI or similar database? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the facility agree to submit annualized data from database for appropriate use, complications, and patient safety upon request to BCBSLA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your organization have a peer review program that includes appropriateness, complications, and patient safety? <input type="checkbox"/> Yes <input type="checkbox"/> 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	

Attach a copy of your facility's state license